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MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: OCTOBER 17, 1994
See the Register Index for Subsequent Rulemaking Activity.

NEXT UPDATE: SUPPLEMENT NOVEMBER 21, 1994

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

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

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NEW JERSEY REGISTER

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EXECUTIVE ORDER

(a)

OFFICE OF THE GOVERNOR
Governor Christine Todd Whitman
Executive Order No. 28(1994)
Retention of Benefits for State Employees Called to Active Duty During the Haiti Crisis and Middle East Crisis

Issued: November 16, 1994.
Effective: November 16, 1994.
Expiration: Indefinite.

WHEREAS, the President of the United States has authorized the peaceful deployment of United States military forces to Haiti as part of a multinational force, authorized by United Nations Security Council Resolution 940; and

WHEREAS, the President has authorized the deployment of United States military forces to the Middle East in an effort to prevent Iraq from invading Kuwait; and

WHEREAS, the President has authorized the Secretary of Defense to call up select members of the Reserve and National Guard to active duty, and has authorized the Secretary of Transportation to call up members of the Coast Guard Reserve, during the Haiti crisis and the Middle East crisis; and

WHEREAS, Reserve and National Guard members who are activated during these crises serve a vital national interest for which they deserve the full support of the citizens of this State; and

WHEREAS, the State of New Jersey recognizes that a strong, ready Reserve and National Guard are essential to the defense of this country and vital to this State in times of emergency; and

WHEREAS, the State of New Jersey recognizes the personal and economic sacrifices of its employees serving in the Reserve and the National Guard who are called to active duty during the Haiti crisis and Middle East crisis.

NOW, THEREFORE, I, CHRISTINE TODD WHITMAN, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of this State, do hereby Order and Direct:

1. New Jersey state employees who are called to active duty during the Haiti crisis or the Middle East crisis shall be entitled upon termination of active duty to return to State employment with full seniority and benefits consistent with State and federal military reemployment and seniority rights.

2. During active duty for the duration of their activation in these crises, these State employees shall be entitled to receive a salary equal to the differential between the employee's State salary and the employee's military pay.

3. These State employees shall be entitled to State employee health benefits, life insurance and pension coverage during active duty service for which they receive differential salary as prescribed in this Order as if they were on paid leave of absence.

4. The Commissioner of Personnel shall implement this Executive Order and each department, office, division or agency of the State is authorized and directed, to the extent not inconsistent with law, to cooperate with the Commissioner of Personnel and to make available to the Commissioner such information, personnel and assistance as necessary to accomplish the purposes of this Order.

This Order shall take effect immediately.

REORGANIZATION PLAN

(a)

OFFICE OF THE GOVERNOR
Governor Christine Todd Whitman
Reorganization Plan No. 002-1994
A Plan for the Reorganization of the Department of Community Affairs

Take notice that on November 21, 1994, Governor Christine Todd Whitman hereby issues the following Reorganization Plan (No. 002-1994) to provide: (1) for the increased efficiency, coordination and functioning of the Department of Community Affairs by reorganizing the Divisions of the Department of Community Affairs; (2) for the increased efficiency, coordination and integration of the State's programs for elderly persons by the transfer of the functions, powers, and duties of the Office of the Ombudsman for the Institutionalized Elderly and the Office of the Public Guardian for Elderly Adults to the Division of Aging in the Department of Community Affairs and by reorganization of the Division on Aging; and (3) for the increased efficiency, coordination and integration of the State's program to provide minimum standards for safety orientation and skills training programs for volunteer athletic coaches, managers, and officials by the transfer of the rule-making authority of the Governor's Council on Physical Fitness and Sports to the Commissioner of the Department of Community Affairs.

GENERAL STATEMENT OF PURPOSE

Pursuant to the 1972 Reorganization Plan of the Department of Community Affairs, three Assistant Commissioners of Community Affairs were provided to assist the Commissioner. In order to more efficiently manage and administer the Department of Community Affairs, this Plan seeks to provide for a Deputy Commissioner of Community Affairs and two Assistant Commissioners of Community Affairs who will serve at the pleasure of the Commissioner and perform such duties as may be prescribed by her. Further, the 1972 Reorganization Plan of the Department of Community Affairs established a Program Analysis Office to assist the Commissioner in developing new programs and performing contract reviews of all grants and contracts for services awarded by the Department of Community Affairs. The functional responsibilities of this Office are currently provided by various Divisions in the Department and it is not necessary to continue the formal existence of the Program Analysis Office.

Pursuant to its present statutory authority, it is the duty of the Department of Community Affairs, among other responsibilities, to provide financial and technical assistance to nonprofit and local government agencies in an effort to improve the quality of life for the State's low-income, handicapped, and disadvantaged residents. These responsibilities are currently administered through various programs in the Division of Human Resources and the Division of Housing and Urban Renewal. The Division of Housing and Urban Renewal, in addition to administering these programs, also administers various statutes which enforce health and safety standards in multiple dwellings, rooming and boarding houses, and new construction. The purpose of this Reorganization Plan, in part, is to create a governmental structure that will foster the efficient implementation of a coherent public policy of integrated assistance to the public and local government agencies. The Plan accomplishes this by transferring the various financial assistance programs administered by the Division of Housing and Urban Renewal to the Division of Human Resources. These Divisions are also being renamed to reflect more accurately their functional responsibilities. This Plan will rename the Division of Housing and Urban renewal as the Division of Codes and Standards and rename the Division of Human Resources as the Division of Housing and Community Resources.

Another essential mission of the Department, pursuant to its present statutory authority, is to provide assistance to individuals and organizations concerned with the well-being of aged persons. These responsibilities are currently carried out through the Department's Division on Aging. The Office of the Ombudsman for the Institutionalized Elderly, pursuant to its present statutory authority, is responsible for protecting the health, safety, and welfare of elderly persons who are patients or residents of health care facilities. The Public Guardian for Elderly Adults, pursuant to its present statutory authority, acts as guardian of or conservator for elderly persons who have been adjudged incompetent by New Jersey courts. The current allocation of responsibilities among these various agencies creates overlapping responsibilities and duplication of services. This Plan will foster the efficient implementation of coherent public policy regarding elderly residents of the State by transferring the functions, powers, and duties of the Ombudsman for the Institutionalized Elderly and the Office of Public Guardian for Elderly Adults to the Division on Aging in the Department of Community Affairs. With the consolidation of the functions, powers, and duties of the Office of the Ombudsman for the Institutionalized Elderly and the Office of Public Guardian for Elderly Adults into the Division on Aging, the Division has enhanced responsibilities to protect and provide services to the elderly residents of the State.

In view of the importance of the Division on Aging to the public, and in order to ensure the efficient implementation of an integrated public policy for the elderly residents of the State, this Plan provides for three Assistant Directors of the Division on Aging to assist the Director. The persons appointed by the Governor and confirmed by the Senate as the Ombudsman for the Institutionalized Elderly and the Public Guardian for Elderly Adults would be Assistant Directors of the Division on Aging in the unclassified service. A position of Assistant Director of the Division on Aging, in the unclassified service, would be created to assist the Director in the management and administration of the Division.

The Governor's Council on Physical Fitness in the Governor's Office was created by Executive Order No. 19 (1982). Thereafter, Executive Order No. 82 (1984) changed the name of the Council to the Governor's Council on Physical Fitness and Sports. Pursuant to Executive Order No. 134 (1986), the Department of Community Affairs was authorized and directed to cooperate with the Council in effecting its purposes. Pursuant to P.L. 1988, c.87, the Governor's Council on Physical Fitness and Sports was authorized, in consultation with the Department of Community Affairs, to promulgate minimum standards for safety orientation and skills training programs for volunteer athletic coaches, managers and officials. These standards were adopted as regulations in 1990. The Governor's Council on Physical Fitness and Sports has, due to loss of funding, ceased to exercise its administrative functions. Nevertheless, the regulations adopted by the Council continue to be necessary so that volunteer athletic coaches, managers, and officials, by virtue of having successfully completed an approved program in accordance with the regulations, can have the benefit of statutory immunity from certain tort liability. Without this immunity, individuals who might otherwise volunteer may decide that it would be imprudent for them to do so. It is therefore necessary that there be a functioning official with authority to readopt these regulations when they expire on January 2, 1995. The official who would most appropriately exercise this authority is the Commissioner of the Department of Community Affairs or her designee.

THEREFORE, in accordance with the provisions of the "Executive Reorganization Act of 1969," L. 1969, c.203 (C.52:14C-1 et seq.), I find with respect to each reorganization included in this Plan that each is necessary to accomplish the purpose set forth in Section 2 of that Act and will do the following:

1. It will promote more effective management of the Executive Branch because it will group similar functions within already existing agencies;
2. It will promote better and more efficient execution of the law by integrating similar functions within already existing agencies;
3. It will group, coordinate, and consolidate functions in a more consistent and practical way according to major purposes;
4. It will reduce expenditures by more closely aligning similar functions; and
5. It will eliminate some overlapping and duplication within the Executive Branch and the Department by consolidating and reallocating certain functions and responsibilities and thereby better utilize the resources of the Executive Branch and the Department.

THE PROVISIONS OF THE REORGANIZATION PLAN ARE AS FOLLOWS:

1.a. The office of the Commissioner in the Department of Community Affairs shall consist of the Commissioner, a Deputy Commissioner, two Assistant Commissioners, and such other staff members as the Commissioner shall designate. The Deputy Commissioner and the Assistant

Commissioners shall serve at the pleasure of the Commissioner and perform such duties as may be prescribed by her.

1.b. The Commissioner of the Department shall have the power, not inconsistent with the provisions of this Reorganization Plan, to organize the work of the Department in such organizational units as she may determine to be necessary for efficient and effective operation.

1.c. The Program Analysis Office established by the 1972 Reorganization Plan of the Department of Community Affairs is abolished.

I find that this reorganization is necessary to accomplish the purposes set forth in Section 2 of P.L. 1969, c.203. Specifically, this reorganization will promote the more effective management of the Department and the expeditious administration of the public business.

2.a. The Division of Housing and Urban Renewal is renamed the Division of Codes and Standards.

2.b. The Division of Codes and Standards shall be responsible for the administration and enforcement of the Hotel and Multiple Dwelling Law, P.L. 1967, c.76; the State Uniform Construction Code Act, P.L. 1975, c.217; the Planned Real Estate Development Full Disclosure Act, P.L. 1977, c.419; the New Home Warranty and Builders' Registration Act, P.L. 1977, c.467; the Rooming and Boarding House Act of 1979, P.L. 1979, c.496; the Limited Dividend Nonprofit Housing Corporations or Associations Law, P.L. 1949, c.184; the Long-Term Tax Exemption Law, P.L. 1991, c.431 (exclusive of the functions assigned by statute to the Division of Local Government Services); the Emergency Shelters for the Homeless Law, P.L. 1985, c.48; the Continuing Care Retirement Community Regulation and Financial Disclosure Act, P.L. 1986, c.103; the Site Improvement Standards Act, P.L. 1993, c.32 (exclusive of the functions assigned by statute to the Site Improvement Advisory Board); and all acts amending or supplementing any of these acts. This Division shall exercise all functions assigned to the Department, either now or in the future, concerning building codes, housing codes, landlord-tenant information or the rights of purchasers of new homes or of units or interests in planned real estate developments.

2.c. The Director of the Division of Codes and Standards shall be a voting member of the Site Improvement Advisory Board established pursuant to P.L. 1993, c.32. The designation of the Director of the Division of Housing in the Department of Community Affairs as a voting member of the Site Improvement Advisory Board, pursuant to P.L. 1993, c.32, is eliminated.

I find that this reorganization is necessary to accomplish the purposes set forth in Section 2 of P.L. 1969, c.203. Specifically, this reorganization will promote the more effective management of the Department and the expeditious administration of the public business, and will increase the efficiency of the operations of the Department.

3.a. The Division of Human Resources is renamed the Division of Housing and Community Resources.

3.b. The Division of Housing and Community Resources shall exercise all of the powers and functions of the Division of Human Resources pursuant to the 1972 Reorganization Plan of the Department of Community Affairs, exclusive of the powers and functions exercised by the Division on Aging and the Division on Women. In addition, this Division shall be responsible for the administration of the functions assigned to the Department under the Department of Community Affairs Demonstration Grant Law of 1967, P.L. 1967, c.82; the Maintenance of Viable Neighborhoods Act, P.L. 1975, c.248; the Neighborhood Preservation Housing Rehabilitation Loan and Grant Act of 1975, P.L. 1975, c.249; the Prevention of Homelessness Act (1984), P.L. 1984, c.180; the Relocation Assistance Law of 1967, P.L.1967, c.79; the Relocation Assistance Act, P.L.1971, c.362; the Fair Housing Act, P.L. 1985, c.222, the Local Redevelopment and Housing Law, P.L. 1992, c.79; any acts amending or supplementing any of these acts; and any and all State and federally funded programs, existing either now or in the future, other than those within the jurisdiction of the Division on Aging, the Division on Women or the Division of Fire Safety, providing financial or technical assistance to individuals, housing sponsors or community organizations.

I find that this reorganization is necessary to accomplish the purposes set forth in Section 2 of P.L. 1969, c.203. Specifically, this reorganization will promote the more effective management of the Department and the more expeditious administration of the public business, will increase the efficiency of the operations of the Department, and will group, coordinate and consolidate the functions of the Department according to major purposes.

4.a. The Office of Ombudsman for the Institutionalized Elderly, created pursuant to P.L. 1977, c.239, and allocated in but not of the Department of Community Affairs, and all of its functions, powers, and duties are continued and transferred to the Division on Aging in the Department of Community Affairs. These functions, powers, and duties shall be organized and implemented within the Division on Aging as determined by the Commissioner of the Department of Community Affairs.

4.b. The position of Ombudsman for the Institutionalized Elderly created pursuant to P.L. 1977, c.239, Section 4, is continued and transferred to the Division on Aging in the Department of Community Affairs. The Ombudsman will be appointed as provided in P.L. 1977, c.239, Section 4.

I find that this reorganization is necessary to accomplish the purposes set forth in Section 2 of P.L. 1969, c.203. Specifically, this reorganization will promote the more effective management of the Executive Branch and its agencies, it will reduce expenditures and promote economy to the fullest extent consistent with the efficient operation of the Executive, it will increase the efficiency of the operations of the Executive to the fullest extent practicable, it will group, coordinate and consolidate agencies and functions of the Executive according to major purposes, it will reduce the number of agencies by consolidating those having a similar function under a single head, and it will eliminate overlapping and duplication of effort.

5.a. The Office of Public Guardian for Elderly Adults, created pursuant to P.L. 1985, c.298, and allocated in but not of the Department of Community Affairs, all of its functions, powers, and duties, are continued and transferred to the Division on Aging in the Department of Community Affairs. These functions, powers, and duties shall be organized and implemented within the Division on Aging as determined by the Commissioner of the Department of Community Affairs.

5.b. The position of Public Guardian for Elderly Adults, created pursuant to P.L. 1985, c.298, Section 5, is continued and transferred to the Division on Aging in the Department of Community Affairs. The Public Guardian will be appointed as provided in P.L. 1985, c.298, Section 5.

I find that this reorganization is necessary to accomplish the purposes set forth in Section 2 of P.L. 1969, c.203. Specifically, this reorganization will promote the more effective management of the Executive Branch and its agencies, it will reduce expenditures and promote economy to the fullest extent consistent with the efficient operation of the Executive, it will increase the efficiency of the operations of the Executive to the fullest extent practicable, it will group, coordinate, and consolidate agencies and functions of the Executive according to major purposes, it will reduce the number of agencies by consolidating those having a similar function under a single head, and it will eliminate overlapping and duplication of effort.

6.a. The Director of the Division on Aging shall be appointed as provided in P.L. 1967, c.42, Section 7.

6.b. The Director of the Division on Aging shall be assisted by three Assistant Directors.

6.c. The person appointed as Ombudsman for the Institutionalized Elderly shall be an Assistant Director of the Division on Aging. This position shall be in the unclassified service.

6.d. The person appointed as the Public Guardian for Elderly Adults shall be an Assistant Director of the Division on Aging. This position shall be in the unclassified service.

6.e. A position of Assistant Director of the Division on Aging is created to assist the Director in the management and administration of the various programs of the Division. This position shall be in the unclassified service.

I find that this reorganization is necessary to accomplish the purposes set forth in Section 2 of P.L. 1969, c.203. Specifically, this reorganization will promote the more effective management of the Executive Branch and its agencies, it will reduce expenditures and promote economy to the fullest extent consistent with the efficient operation of the Executive, it will increase the efficiency of the operations of the Executive to the fullest extent practicable, and it will eliminate overlapping and duplication of effort.

7.a. The authority conferred upon the Governor's Council on Physical Fitness and Sports, pursuant to P.L. 1988, c.87 (C.2A:62A-6), to adopt minimum standards for safety orientation and skills training programs for volunteer athletic coaches, managers and officials, is hereby transferred to the Commissioner of the Department of Community Affairs or her designee.

I find that this reorganization is necessary to accomplish the purposes set forth in Section 2 of P.L. 1969, c.203. Specifically, this reorganization will promote the more effective management of the Executive Branch

and its agencies, it will reduce expenditures and promote economy to the fullest extent consistent with the efficient operation of the Executive, it will increase the efficiency of the operations of the Executive to the fullest extent practicable, and it will eliminate overlapping and duplication of effort.

8. All employees of the Office of the Ombudsman for the Institutionalized Elderly and the Office of the Public Guardian for Elderly Adults who are serving in the unclassified service of the State as of the effective date of this Reorganization Plan, other than those individuals serving in the positions of Ombudsman for the Institutionalized Elderly, Public Guardian for Elderly Adults, Confidential Secretary, Confidential Assistant, and General Counsel, shall, upon the transfer of those offices and the position therein to the Division on Aging, have the titles in which they are serving reallocated to the career service. Such individuals shall be permitted to occupy such position without being subjected to an examination process. All employees whose titles are reallocated to the career service shall, however, be required to satisfactorily complete a working test period before attaining permanent status in such titles within the career service.

9. All transfers directed by this Plan shall be made in accordance with the "State Agency Transfer Act," L. 1971, c.375 (C.52:14D-1 et seq.)

10. All acts and parts of acts inconsistent with any of the provisions of this Reorganization Plan are superseded to the extent of such inconsistencies. A copy of this Reorganization Plan was filed on November 21, 1994 with the Secretary of State and the Office of Administrative Law for publication in the *New Jersey Register.* This Plan shall become effective in 60 days on January 20, 1995 unless disapproved by each House of the Legislature by the passage of a concurrent resolution stating in substance that the Legislature does not favor this Reorganization Plan, or at a date later than January 20, 1995, should the Governor establish such a later date for the effective date of the Plan, or any part thereof, by Executive Order.

TAKE NOTICE that this Reorganization Plan, if not disapproved, has the force and effect of law and will be printed and published in the annual edition of the public laws and the *New Jersey Register* under a heading of "Reorganization Plans."

RULE PROPOSALS

ADMINISTRATIVE LAW

(a)

OFFICE OF ADMINISTRATIVE LAW

Notice of Public Hearing and Extension of Comment Period
Special Hearing Rules
Department of Environmental Protection Cases
Proposed New Rules: 1:7A-1.1 and 8.1

Take notice that the New Jersey Office of Administrative Law will hold a **public hearing** to elicit public comments on proposed new rules N.J.A.C 1:7A-1.1 and 8.1, published in the October 17, 1994 New Jersey Register at 26 N.J.R. 4124(a). This public hearing has been scheduled at the request of the Assembly Regulatory Oversight Committee, pursuant to N.J.S.A. 52:14B-4(a)(3). The hearing will solicit comments concerning the proposed rule which permits the DEP to retain a case for an additional 30 days, with the consent of the parties, prior to transmittal to the OAL in order to facilitate settlement discussions.

The public hearing will be conducted by Randye Bloom, Assistant Director, Office of Administrative Law, who will file a report on the hearing with the Director of the Office of Administrative Law. The hearing will be held on Tuesday, January 10, 1995 beginning at 10:00 A.M. at:

Office of Administrative Law
9 Quakerbridge Plaza, Bldg. 9
Quakerbridge Road—CN 049
Trenton, New Jersey 08625

Take further notice that, in accordance with N.J.A.C. 1:30-3.3(c), the public comment period for this proposal is extended to January 10, 1995. Submit comments by that date to:

Jeff S. Masin, Acting Director
Office of Administrative Law
Quakerbridge Plaza, Bldg. 9, CN 049
Quakerbridge Road
Trenton, New Jersey 08625

BANKING

(b)

DIVISION OF REGULATORY AFFAIRS

Check Cashing
Proposed New Rules: N.J.A.C. 3:24
Proposed Amendment: N.J.A.C. 3:23-2.1

Authorized By: Elizabeth Randall, Commissioner, Department of Banking.

Authority: N.J.S.A. 17:15A-30 et seq., 17:1-8, 17:1-8.1.

Proposal Number: PRN 1994-572.

Submit comments by January 18, 1995 to:

Elaine W. Ballai
Regulatory Officer
Department of Banking
CN 040
Trenton, N.J. 08625

The agency proposal follows:

Summary

N.J.S.A. 17:15A-1 et seq. was repealed by P.L. 1951, c.187 and re-enacted by P.L. 1993, c.383, effective on April 11, 1994, as N.J.S.A. 17:15A-30 et seq. known as "The Check Cashers Regulatory Act of 1993." The Act defines terms, establishes capital or net worth and liquid assets requirements for each office or mobile office, provides minimum application requirements, sets fees which check cashers may charge for cashing checks, establishes requirements for the conduct of business and recordkeeping, imposes restrictions on location of check cashing facilities, sets fees chargeable by the Department of Banking and penalties imposed on licensees for violations of rules.

The proposed new rules are necessary and are being proposed because the Commissioner is directed to promulgate rules and regulations pursuant to the new Act and because, pursuant to Executive Order No. 66(1978), the rules concerning check cashing at N.J.A.C. 3:24 expired on August 18, 1994.

The proposed N.J.A.C. 3:24-1 provides definitions of key terms not already defined by N.J.S.A. 17:15A-31 and establishes requirements for applications and licensing fees.

Proposed N.J.A.C. 3:24-2 requires the applicant to furnish proof of net worth and liquid assets as required by N.J.S.A. 17:15A-37 and to make the accountant's records available for inspection in New Jersey.

Proposed N.J.A.C. 3:24-3 requires the applicant to demonstrate compliance with applicable State, County and Municipal laws and ordinances.

Proposed N.J.A.C. 3:24-4 sets limits on the type of fees which a licensee may charge for cashing a check, and the location and content of signs which a licensee must post at every location where checks are cashed.

Proposed N.J.A.C. 3:24-5 regulates the licensees' conduct of business, including check cashing procedures, recordkeeping, cash reconcilement, deposits and prohibitions on commingling funds or records of the check cashing business with those of other businesses conducted on the same premises.

Proposed N.J.A.C. 3:24-6 sets forth requirements for additional reports to the Commissioner, requires that copies of Currency Transaction Reports be filed with the Commissioner and establishes a fee for filing each such report.

The proposed amendment to N.J.A.C. 3:23-2.1 sets forth the increase in license fees for check cashers; the biennial license fee is increased from $1,000 to $1,200. The maximum biennial fee is increased from $1,000 to $2,000 and the annual fee is increased from $500.00 to $600.00.

Social Impact

These rules have been drafted to comply with the legislative mandate in N.J.S.A. 17:15A-52 which requires the department to promulgate new rules to implement the Check Cashers Regulatory Act of 1993. Both the new law and these rules are designed to promote financial responsibility of licensees and to maintain the integrity of the check cashing industry. An applicant for a check cashers license must now demonstrate that he or she possesses a capital or net worth of at least $50,000 for each office or mobile office and liquid assets of at least $50,000 for each office or mobile office. Fees permitted to be charged for cashing checks have been increased, record keeping regulations have been tightened, and restrictions have been added on licensees' conduct of business. These changes are designed ultimately to benefit the general public by increasing the public's confidence in the honesty, efficiency and reliability of the services rendered.

Economic Impact

Pursuant to the authority granted by the Legislature in the Check Cashers Regulatory Act of 1993, fees charged by licensees have been increased and separate categories of fees have been added for checks payable to persons under Aid To Families With Dependent Children (AFDC) and Supplemental Social Security. The increased check cashing fees will assist the check cashers in offsetting increased license fees, charges imposed for filing required reports and increased application fees. While the cost of doing business may be increased by these rules, it is anticipated that certain abuses will be curtailed and the impact will be to promote healthy competition among check cashing establishments. This is consistent with legislative intent embodied in the legislation, which is to protect and serve the public interest by providing check cashing services to the general public at a reasonable cost.

Regulatory Flexibility Analysis

Most check cashers are small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-1 et seq. These rules impose recordkeeping, reporting and compliance requirements on all applicants and licensees, and are necessary both to meet statutory mandates and to monitor compliance with the rules. Recordkeeping requirements, in addition to those spelled out in N.J.S.A. 17:15A-30 et seq., include a Summary of Business Record, return items record, and daily cash reconcilement. Funds and records of the check cashing business

are required to be kept separate from funds and records of other businesses conducted on the same premises. Although these requirements are more detailed than required by N.J.S.A. 17:15A-30 et seq., no differentiation is made for small businesses, because the check cashing activities, fees collected and procedures are the same for small as well as large businesses, and the need for Department examiners to monitor all of these factors is the same for all. The purpose of these requirements is to maintain the integrity of the check cashing industry, to promote healthy competition and to provide services to the general public. Licensees will incur professional expenses to establish the recordkeeping and auditing requirements of these rules; however, these expenses are not believed to be prohibitive and are necessary to insure the financial integrity of the check cashing businesses, as well as the protection of the public.

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

3:23-2.1 Licensees

The following table indicates the license fees established by the Commissioner of Banking for annual and biennial license periods, the maximum biennial license fees permitted by law and the specific statutory sections affected by the establishment of such biennial and annual license fees.

	STATUTORY
. . . .	
Check Casher	$[1,000.00] **2,000.00** $[1,000] **1,200.00** $[500.00] **600.00** (N.J.S.A. 17:15A-40)
. . . .	

CHAPTER 24
CHECK CASHING

SUBCHAPTER 1. GENERAL PROVISIONS

3:24-1.1 Purpose

The purpose of this chapter is to implement and to augment the requirements of N.J.S.A. 17:15A-30 et seq., "The Check Cashers Regulatory Act of 1993."

3:24-1.2 Scope

These rules are applicable to all licensed check cashers and applicants for licensure.

3:24-1.3 Definitions

Words and terms, when used in this chapter, shall have the meanings as defined at N.J.S.A. 17:15A-31 unless defined below or the context clearly indicates otherwise.

"Act" means N.J.S.A. 17:15A-30 et seq., "The Check Cashers Regulatory Act of 1993."

"Appropriate documentation" means a corporate resolution filed with the Secretary of State, Federal taxpayer identification number, filed New Jersey Certificate of Authority, filed trade-name certificate or other readily verifiable official document.

"Cash" (cashing a check) includes both the exchange of money for the presentment of a check, and the acceptance of a replacement check for one which has been returned for insufficient funds.

"Consideration" means, but is not limited to, a requirement by the check casher that a person make a purchase or otherwise patronize a business operated by the check casher in order to cash a check at the check cashing establishment, or a returned check charge imposed by a bank.

"Disabled person" means, for the purpose of these rules, a person whose disability either temporarily or permanently prevents him from going into a check cashing establishment for the purpose of cashing a check.

"Essential records" includes all records listed in N.J.S.A. 17:15A-44l and m; N.J.A.C. 3:24-5.3(a); and all corporate resolutions.

"Insolvent" means that the check cashing licensee cannot or does not pay his or her debts as they become due in the normal course of business, or his or her financial statement indicates that the licensee has a negative net worth.

"Person" includes corporations, companies, associations, societies, firms, partnerships and joint stock companies as well as individuals, unless the context clearly indicates otherwise.

3:24-1.4 License fees; reporting fee

(a) The Department shall charge the following biennial fees to apply for or renew a license pursuant to this chapter:

1. A licensing fee of $1,200 for a principal office;

2. A licensing fee of $1,200 for a full branch office; and

3. A licensing fee of $1,200 for a mobile office.

3:24-1.5 Application fees

(a) The following application fees shall be charged:

1. Application for a principal office, $250.00;

2. Application for a full branch office, $250.00;

3. Application for a limited branch office, $250.00;

4. Application for a mobile office, $250.00, plus $100.00 for each additional geographic location at which the mobile office will stop;

5. Application for change of control pursuant to N.J.S.A. 17:15A-42, $100.00; and

6. Application for approval to change the address of an existing office, $75.00.

3:24-1.6 Application process; requirements

(a) No applicant for a license shall commence operations until a license has been issued.

(b) In addition to the information required to be furnished to the Department by N.J.S.A. 17:15A-33 through 39, the applicant shall supply the following as part of its application for each director, substantial stockholder, officer, owner, partner, manager and employee of the business to be licensed:

1. A Certificate of Certified Consent for criminal investigative purposes;

2. Photographs of the persons listed in (b) above;

3. A fingerprint card supplied with application (Form FD-258);

4. Application fee(s) as required by N.J.A.C. 3:24-1.3;

5. Any other information or supporting documentation relating to the operation of the proposed check cashing business which the Commissioner may require; and

6. A check in the amount of $50.00 for each person for the costs of background investigations, including fingerprinting;

(c) Corporate applicants for a check cashing license shall submit a copy of the Certificate of Incorporation showing the filed or recording stamp of the New Jersey Secretary of State, and shall identify the registered agent for service of process. Foreign corporations shall submit a New Jersey Certificate of Authority in addition to corporate certificate.

(d) Individual or partnership applicants using a trade name shall submit a copy of the trade name as filed with the county clerk showing date of recording.

(e) Corporations using fictitious names shall file a copy of registration of such name, as recorded, as part of their applications.

(f) A new employee, hired after a license has issued, may begin work pending receipt by the Department of fingerprint results provided all other information is complete and satisfactory.

SUBCHAPTER 2. FINANCIAL RESPONSIBILITY

3:24-2.1 Proof of net worth; records

(a) An applicant shall submit to the Department an unqualified, audited financial statement prepared by a Certified Public Accountant or a public accountant, sufficient to satisfy the capital and net worth requirements of N.J.S.A. 17:15A-37.

(b) In the event the accountant does not maintain an office in New Jersey, the licensee's records shall be examined at the licensee's main office.

SUBCHAPTER 3. PLACE OF BUSINESS

3:24-3.1 Compliance with State and local law

The applicant shall supply necessary permits, variances or other documentation sufficient to demonstrate that the facility is in compliance with all applicable State, county and municipal laws, ordinances and traffic regulations.

SUBCHAPTER 4. CHECK CASHING FEES; POSTING

3:24-4.1 Returned check fee; prohibition

No licensee shall impose any charge or fee for a returned check.

3:24-4.2 Posting of fees; signs

(a) The licensee shall post and at all times display in a conspicuous place on the premises the license and also the schedule of fees to be charged. The Department shall determine the number of signs which shall be posted and shall designate those areas in the check cashing facility where these signs will be displayed, depending upon the size of the office and its physical layout. These signs shall be in both the English and Spanish language except where the Department deems it necessary that a different or additional language be used.

(b) Each sign shall be printed on heavy cardboard or other durable material, with printed information in a minimum of 22 point type with appropriate headings of at least 24 point bold type. These signs shall read as follows:

STATE LICENSED CHECK CASHER
MAXIMUM FEES YOU CAN BE CHARGED
2% OF YOUR CHECK

Example:

New Jersey check	$300.00	
Maximum fee	6.00	2%
Cash to you	$294.00	

CHECKS PAYABLE TO PERSON UNDER AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)
1% OF YOUR CHECK

Example:

AFDC check	$300.00	
Maximum fee	3.00	1%
Cash to you	$297.00	

SUPPLEMENTAL SECURITY INCOME CHECKS (Sub XVI)
1½% OF YOUR CHECK

Example:

SSI check	$300.00	
Maximum fee	4.50	1½%
Cash to you	$295.50	

SUBCHAPTER 5. CONDUCT OF BUSINESS

3:24-5.1 Check cashing procedure

(a) In addition to the requirements of N.J.S.A. 17:15A-44c, e, and j, each licensee shall:

1. Pay to every customer tendering any check, draft or money order to be cashed, the entire face amount of such instrument in cash less any charges permitted by law, on the same date upon which such instrument is presented;

2. Indicate on every check, draft or money order cashed at the time of cashing, the date on which such item was cashed; and

3. Give each person presenting a check, draft or money order for cashing upon completion of each transaction an itemized receipt indicating the name of the check casher, the teller number indicating which teller completed the transaction, the amount of the check cashed, the amount of the fee charged to cash the check and the amount of cash given to the person cashing the check.

3:24-5.2 Recordkeeping

(a) In addition to the requirements of N.J.S.A. 17:15A-44l, a Summary of Business Record shall be maintained in which the number of checks, drafts, or money orders cashed, their total face amount, and the aggregate fees received, shall be shown for each business day and totaled for each calendar month. If this information is included in a horizontal form of daily cash reconcilement, such record will be acceptable in lieu of a separate summary of business. The summary record shall consist of five categories:

1. All two percent checks cashed;

2. All one percent checks cashed, including AFDC checks;

3. All one and one-half percent checks cashed, including SSI checks;

4. All no-fee checks cashed; and

5. All check cashing customer receipts.

(b) A viewable photographic record of checks, drafts and money orders cashed, which sets forth all the information pertaining to said checks, drafts and money orders required by N.J.S.A. 17:15A-44d and l and (a) above will be acceptable in lieu of the records required by this section.

1. In such event, the photographic film must be processed promptly after each roll of film has been exposed, and the viewable records maintained by the licensee for at least three years after the date of the last photograph on the roll.

2. The licensee shall maintain a log indicating the beginning and ending business days covered by each individual roll of processed photographic records.

(c) Each licensee shall reconcile its bank statement at least monthly.

3:24-5.3 Return items record

(a) A return items record shall be maintained in which the following information shall be clearly recorded with respect to each check, draft or money order, returned unpaid:

1. The date on which each check, draft or money order was originally cashed by licensee;

2. The issuer of each check, draft or money order;

3. The date of each check, draft or money order returned unpaid;

4. The name of the drawer of each check, draft or money order returned unpaid;

5. The name of the payee or last endorser of each check, draft or money order;

6. The amount of each check, draft or money order returned unpaid;

7. The name of the bank on which each check, draft or money order is drawn;

8. The reason for which each check, draft or money order was returned unpaid;

9. The date on which each check, draft or money order was redeposited;

10. The date and manner of payment of each check, draft or money order, with complete details of the disposition made of it, including a record of the specific check, draft or money order utilized in the payment of the original item; and

11. A current record, updated weekly, showing the efforts and progress being made to collect any unpaid checks, drafts, or money orders, including the receipt of partial payments.

3:24-5.4 Daily cash reconcilement

(a) A daily cash reconcilement shall be maintained which shall contain the following information:

1. Cash on hand at opening of business;

2. Checks, drafts or money orders cashed the previous day and on hand at opening of business;

3. Cash received during the day showing in detail the source of funds;

4. The total amount of fees received during the day;

5. The sum of items (a)1 through 4 above;

6. The total deposits made during the day;

7. Other cash paid out during the day showing in detail the nature of the disbursement;

8. The sum of items (a)6 and 7 above;

9. Item(a)5 less item (a)8 above, representing the cash on hand and the total of undeposited checks, drafts or money orders, cashed during the day;

10. The total of cash included in item (a)9 above; and

11. Cash on hand at close of business day with shortages or overages explained in detail.

3:24-5.5 Deposits

(a) Except as hereinafter stated, all checks, drafts and money orders shall be deposited in the licensee's account in an institution in this State situated in the vicinity of the licensed location, not later than the first business day following the day on which they

were cashed. Such items shall be deposited during regular business hours so as to enable credit for the deposits to the licensee's account on that business day.

(b) When the number of payroll checks cashed amount to 50 or more, the licensee may present such package of checks to the drawee bank or the maker of the checks and receive in exchange a single draft, provided full details of the transaction are recorded. Separate tapes of these transactions shall be maintained as set forth in N.J.A.C. 3:24-5.2.

(c) All checks, drafts, money orders cashed on any one day and deposited on the same day or next business day shall be deposited under a separate deposit total and not commingled with any other day's business.

(d) A violation of this section shall occur if a licensee instead of depositing all checks, drafts and money orders as required:

1. Cashes all or any of them at another check casher;
2. Exchanges all or any of them for another check or checks; or
3. Negotiates all or any of them in any manner or for any purpose other than that provided in this section.

3:24-5.6 Dual business deposit and record requirements

(a) The checks, drafts, money orders or cash of any other business in which the licensee is engaged shall not be commingled with other funds in the licensee's bank account or with the cash or checks on hand.

(b) Separate records shall be kept for a check cashing business conducted on the same premises where another business is also operated. In such cases the licensee shall apportion to the check cashing business its share of expense. Reasonable estimates may be used.

3:24-5.7 Prohibitions

(a) In addition to the prohibitions contained in N.J.S.A. 17:15A-30 et seq., no licensee or person acting on behalf of a licensee shall:

1. Cash a check made payable to "cash";
2. Cash a check using any form of consideration other than cash; or
3. Cash a check for anyone other than the payee named on the face of the check, except where the presenter of the check to be cashed has obtained a written, notarized authorization from a disabled payee specifically requesting the presenter to cash the check.

SUBCHAPTER 6. ADDITIONAL REPORTS

3:24-6.1 Additional reports; fee

(a) In any case in which the Commissioner finds that reasonable grounds exist for requiring additional recordkeeping and reporting, the Commissioner may issue an order requiring any licensee or group of licensees in a geographic area to provide information regarding transactions that involve a total dollar amount or denomination of $2,500 or more, including the names of the persons participating in those transactions.

(b) The licensee shall supply to the Commissioner and the New Jersey Division of Taxation a copy of any Currency Transaction Report it is required to file with the Federal government.

(c) Licensees filing a report pursuant to this section shall pay a fee of $50.00 for each such report filed.

COMMUNITY AFFAIRS

(a)

THE COMMISSIONER

Standards of Conduct

Proposed Readoption with Amendments: N.J.A.C. 5:1

Authorized By: Harriet Derman, Commissioner, Department of Community Affairs.

Authority: N.J.S.A. 52:27D-3.

Proposal Number: PRN 1994-641.

Submit written comments by January 18, 1995 to:

Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, NJ 08625
Fax No. (609) 633-6729

The agency proposal follows:

Summary

N.J.A.C. 5:1, which sets forth rules concerning standards of conduct for officers and employees of the Department of Community Affairs, is scheduled to expire on February 5, 1995, pursuant to Executive Order No. 66(1978).

The Department of Community Affairs has reviewed these rules and finds that they continue to be necessary and appropriate to facilitate compliance with applicable statutes concerning ethical standards, nondiscrimination and political activities.

N.J.A.C. 5:1 includes rules concerning fair employment practices, conflict of interest and ethical standards, and political activities. Amendments are proposed at N.J.A.C. 5:1-5.2 and 5.3 dealing with fair employment practices in order to reflect recent amendments to the Law Against Discrimination, and at N.J.A.C. 5:1-7.1 and 7.2 to correct the section headings.

Social Impact

The rules included in this chapter have the socially beneficial effect of providing notice both to persons employed by the Department and to the general public of standards of conduct with which officers and employees of the Department are required to comply. The fact that the standards are made clear facilitates the taking of necessary action in the event of any violation.

Economic Impact

The purpose of these rules is to facilitate compliance with laws concerning fair employment practices, ethical standards and political activity. The rules themselves have no particular economic impact.

Regulatory Flexibility Statement

These rules primarily affect persons employed by, or seeking to be employed by, the Department of Community Affairs. They do not have any effect upon small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16, et seq.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 5:1.

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

5:1-5.2 Personnel actions

In furtherance of [Section 5.1 (Conduct) of this Chapter] **N.J.A.C. 5:1-5.1**, this Department's policy is that all personnel actions, including, but without limitation, employment, promotion, demotion, transfer, recruitment, layoff or termination, rates of pay or other forms of compensation and work assignments shall be conducted on a wholly nondiscriminatory basis, and shall be on the basis of merit alone; provided, however, that nothing contained herein shall be construed to forbid the employment or upgrading of those persons who, by reason of prior invidious discrimination on the basis of race, creed, color, religion, national origin, ancestry, age, **marital status, affectional or sexual orientation,** sex, **atypical hereditary cellular or**

blood trait, or liability for service[s] in the Armed Forces of the United States have been heretofore prevented from attaining their full productive potential.

5:1-5.3 Inquiries

No person shall inquire, or cause an inquiry to be made, with respect to the race, creed, color, religion, national origin, ancestry, age, **marital status, affectional or sexual orientation,** sex, **atypical hereditary cellular or blood trait,** or liability for service[s] in the Armed Forces of the United States of any other person or prospective officer or employee of this Department, except to the extent that such inquiry is required by law. In such event, the information so received shall be used only for the purposes for which it was gathered, and under no circumstances shall it be used for any purpose prohibited by these [regulations] **rules** or **by** any applicable law, statute or ordinance.

5:1-7.1 Use **of** opposition or authority; prohibition
(No change in text.)

5:1-7.2 Hatch **Act**
(No change in text.)

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Local Housing Authority and Municipal Redevelopment Agency Training Program

Proposed New Rule: N.J.A.C. 5:16

Authorized By: Harriet Derman, Commissioner, Department of Community Affairs.
Authority: N.J.S.A. 40A:12A-45 and 49.
Proposal Number: PRN 1994-643.

Submit written comments by January 18, 1995 to:
Michael L. Ticktin
Chief of Legislative Analysis
Department of Community Affairs
CN 802
Trenton, New Jersey 08625

The agency proposal follows:

Summary

While most New Jersey housing authorities and redevelopment agencies have been operated competently over the years, an evaluation by the United States Department of Housing and Urban Development (HUD) of housing authority operation and staff competency in the late 1980's revealed significant problems in at least some housing authorities. In an effort to raise the educational standard for commissioners and executive directors of housing authorities and redevelopment agencies, the Legislature adopted P.L. 1992, c.79 (N.J.S.A. 40A:12A-1 et seq.), which includes provisions addressing the professional development needs of these officials by mandating training courses.

In addition to revising, consolidating and clarifying existing provisions of law related to the exercise of redevelopment and housing powers by local governments, this statute mandates comprehensive training for executive directors and commissioners in order to assure effective management and operation of housing authorities and redevelopment agencies. It authorizes the Commissioner of Community Affairs to prescribe and enforce standards for the training program.

Accordingly, the Department is now proposing new rules at N.J.A.C. 5:16 that will establish standards for the mandatory local housing authority and municipal redevelopment agency training program. The proposed new rules also include provision at N.J.A.C. 5:16-3.1(b) for review of the qualifications for employment of prospective executive directors. These standards specify course requirements and training curricula, course equivalency determinations, experience and education requirements, waivers and exemptions. The proposed new rules were written with input from a Housing Authority and Redevelopment Agency Training Advisory Committee consisting of representatives of the New Jersey National Association of Housing and Redevelopment Officials (NJNAHRO), the New Jersey Association of Housing and Redevelopment Authorities (NJAHRA), the United States Department of Housing and Urban Development (HUD), Rutgers, the State University, the Department of Community Affairs, Quadel Consulting Corporation and the National Association of Housing and Redevelopment Officials (NAHRO), two nationally recognized training organizations, and executive directors and commissioners of New Jersey housing authorities.

The proposed new rules at N.J.A.C. 5:16-2.5 would establish standards for granting waivers from the education and experience requirements and/or training program courses for those individuals submitting approved equivalency determinations.

N.J.A.C. 15:16-1 sets forth general provisions and defines the terms used throughout the chapter.

N.J.A.C. 15:16-2 sets forth the training program requirements and program administration including compliance.

N.J.A.C. 15:16-3 sets forth education and experience requirements and enforcement standards.

N.J.A.C. 15:16-4 specifies the purpose and standards for the local housing authority and municipal redevelopment agency training program.

Social Impact

The development of a comprehensive training program for commissioners and executive directors of local housing authorities and municipal redevelopment agencies will enhance the competency of these individuals. The course of instruction will provide commissioners and executive directors with knowledge of topics related to management of public housing, publicly assisted housing and redevelopment agencies. In addition, the training will assist these individuals in understanding the functions of a local housing authority or municipal redevelopment agency and diligently overseeing and administering its operations.

The absence of a comprehensive training program to address the needs of commissioners and executive directors of housing authorities and redevelopment agencies may contribute to various problems occurring in public housing across the nation. Training and certification of these individuals will benefit residents of public housing and publicly-assisted housing by ensuring that only individuals possessing the requisite knowledge, training and experience will serve as executive directors or commissioners of local housing authorities or redevelopment agencies.

Public housing and publicly-assisted housing constitute an important source of housing for New Jersey's low- and moderate-income households. The education of those individuals responsible for the daily management and administration of these housing units will also further the development of decent and affordable housing, the addressing of resident needs, the proper maintenance of existing units and prompt attention to health and safety concerns.

Economic Impact

Persons who have the required experience and have satisfactorily completed the required course of study for executive directors will be eligible for appointment or reappointment to this position in housing authorities or redevelopment agencies. This will presumably be of economic benefit to them, since they will qualify for employment for which they would not otherwise be qualified.

When developing the training program, the Housing Authority and Redevelopment Agency Training Advisory Committee recognized that a significant number of commissioners have work, family and civic responsibilities that also place demands on their time. The structuring of the course curriculum recognizes these other demands on an individual's time and meets the legislative intent without being unduly onerous.

Because the law requires the training program to be self-supporting, the Department tried to maintain reasonable costs. The costs for courses is well within the range of, if not lower than, comparable professional development courses. Although the expense for continuing professional education may be a greater burden to very small housing authorities, the value of improving the living conditions for low- and moderate-income households, the State's most vulnerable residents should justify the expenditure. HUD concurs with the State regarding the value of the training program and therefore recognizes the cost of training as an allowable budget expense. Additionally, the cost of the courses may be allocated over two fiscal years, thereby substantially reducing the budget burden. The cost of the training is not a recurring annual expense and additional costs are incurred only for new appointments.

Regulatory Flexibility Analysis

These rules apply to commissioners and executive directors of housing authorities and redevelopment agencies, educational institutions, course providers and instructors developing and offering approved courses and

private organizations seeking designation as State-approved instructors. These latter may be in the category of "small businesses," as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The compliance burden placed upon these small businesses in contacting the Department for designation as a State-approved course sponsor, course instructor or training facilitator is minimal. Satisfying the requirements of these rules regarding development of course curriculum and selection of qualified instructors should not exceed those costs normally associated with the day-to-day business activities of these entities. The assumption of significant additional costs is not required in order to comply with this chapter. Based on these considerations, no differentiation in requirements based on business size is provided.

Full text of the proposed new rules follows:

CHAPTER 16
LOCAL HOUSING AUTHORITY AND MUNICIPAL REDEVELOPMENT AGENCY TRAINING PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

5:16-1.1 Title; scope

(a) The rules contained in this chapter shall be known as the "Rules for the Local Housing Authority and Municipal Redevelopment Agency Training Program."

(b) These rules govern the prescribed training program referred to as Local Housing Authority and Municipal Redevelopment Agency Training Program, hereinafter designated as the LHA/MRA Training Program.

5:16-1.2 Authority

These rules are promulgated by the Commissioner of the Department of Community Affairs pursuant to the authority of the "Redevelopment and Housing Law," (P.L. 1992, c.79; N.J.S.A. 40A:12A-1 et seq.)

5:16-1.3 Intent and purpose

The purpose of the LHA/MRA Training Program shall be to improve the technical expertise and management skills of commissioners and executive directors of local housing authorities and municipal redevelopment agencies through a comprehensive, structured educational program.

5:16-1.4 Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise. All definitions found in the Redevelopment and Housing Law, P.L. 1992, c.79 (N.J.S.A. 40A:12A-1 et seq.), shall be applicable to this chapter.

"Certificate of completion" means written documentation provided to executive directors and commissioners of local housing authorities and municipal redevelopment agencies evidencing successful completion of the required course of study for the LHA/MRA Training Program.

"Commissioner" means an appointed member of the governing board of a local housing authority or a municipal redevelopment agency, which board is responsible for overseeing operations, including developing policy and establishing monitoring controls.

"Commissioner of the Department," or "DCA Commissioner," means the Commissioner of Community Affairs.

"Course curriculum" means the mandatory and elective courses that executive directors and commissioners of local housing authorities and municipal redevelopment agencies must complete to satisfy the training requirements more fully described in N.J.A.C. 5:16-3.

"DCA Commissioner" (See "Commissioner of the Department.")

"Department" means the New Jersey Department of Community Affairs.

"Equivalency agency" means an agency qualified to evaluate training and experience, educational programs, and other license, certificate and training programs offered by educational institutions, and military, employer and professional associations to determine whether the training or experience meets or exceeds the LHA/MRA Training Program requirements.

"Executive director" means an individual employed as the chief officer of a local housing authority or municipal redevelopment agency and responsible for the daily management of the entity.

"Hardship" means any physical, mental or social privation, suffering or adversity that may hinder or preclude an individual from satisfactorily completing the requirements of the LHA/MRA Training Program. The New Jersey Department of Community Affairs will, within reason, provide appropriate accommodations to assist all LHA/MRA Training Program participants to complete both the course curriculum and evaluation components.

"Housing Authority and Redevelopment Agency Training Advisory Committee" means the committee, comprised of staff of the Department of Community Affairs, representatives of the New Jersey National Association of Housing and Redevelopment Officials (NJNAHRO), the New Jersey Association of Housing and Redevelopment Authorities (NJAHRA) and the United States Department of Housing and Urban Development, executive directors and commissioners of housing authorities, representatives of Rutgers, The State University, and two nationally recognized training organizations, that has responsibility for guiding the course of study for the Training Program.

"Local housing authority" means a housing authority created or continued pursuant to the "Redevelopment and Housing Law," P.L. 1992, c.79 (N.J.S.A. 40A:12A-1 et seq.).

"Member" means an individual serving as a member of a local housing authority or a commissioner of a municipal redevelopment agency.

"Municipal redevelopment agency" means a redevelopment agency created or continued pursuant to the "Redevelopment and Housing Law," P.L. 1992, c.79 (N.J.S.A. 40A:12A-11).

"Pre-session evaluation" means the written or oral performance assessment administered by LHA/MRA Training Program instructors at the beginning of each course to familiarize participants with the course material.

"Post-session evaluation" means the written or oral performance assessment administered by LHA/MRA Training Program instructors at the end of the course to assess the participant's understanding of and to reinforce key concepts and significant issues covered during the training session.

"Program participant" means an individual attending approved LHA/MRA Training Program courses.

"Recognized educational agency" means an educational, business, military or professional organization which offers credit or non-credit educational courses which, upon prior approval of the Department, may be judged equivalent to the required LHA/MRA Training Program courses.

"Satisfactory" when used in reference to evaluations, means providing correct responses to no less than 70 percent of the questions.

"State-approved course" means a course offered by an organization or entity other than the New Jersey Department of Community Affairs, Rutgers or other training facilitator that satisfies the requirements of the LHA/MRA Training Program and for which executive directors and commissioners shall receive credit.

"Training facilitator" means an entity recognized and approved by the Department of Community Affairs to develop and offer the LHA/MRA Training Program curriculum.

5:16-1.5 Severability

If any provision of these rules or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of the rules and to this end, the provisions of the rules are severable.

SUBCHAPTER 2. TRAINING REQUIREMENTS AND ADMINISTRATION

5:16-2.1 Training curriculum

(a) The purpose, objectives and content of each course approved as part of the LHA/MRA Training Program curriculum shall meet the standards established and approved by the Department, as set forth in this chapter, and shall address New Jersey rules, programs

and issues. The course of study shall be designed to clarify the functions, duties and limits of housing authorities and redevelopment agencies and the decision-making responsibilities of individuals serving as executive directors or commissioners and to familiarize them with current methods and procedures for managing public housing units, publicly assisted housing, or redevelopment projects.

(b) The course curriculum for commissioners of local housing authorities shall consist of four mandatory and one of five elective courses, ranging in length from one-half day to one day. A half-day program shall be four hours in length, while a full-day program shall be seven hours. Housing authority members must satisfactorily complete all mandatory courses and one elective course within the time prescribed in N.J.A.C. 5:16-2.4(a).

1. The mandatory commissioner courses shall be as follows:

i. Skills for Commissioners: provides a broad overview of the roles and responsibilities of commissioners;

ii. Financial Issues and Procedures: explores a range of financial management skills, including budgets, cost allocations and funding sources;

iii. Public Housing Management Assessment Program (PHMAP): explores how to use PHMAP as a management tool and how to improve an authority's PHMAP scores; and

iv. Ethics: provides an overview of public ethics.

2. Elective courses for commissioners may include, but are not limited to, the following courses. At the discretion of the Department, courses may be added or eliminated, as participant demand and interest dictate.

i. Resident Initiatives;

ii. Current Issues/Programs in Affordable Housing;

iii. Legal Issues;

iv. Public Relations/Communications; and

v. Planning and Development of Affordable Housing.

(c) The course curriculum for executive directors of local housing authorities shall consist of seven mandatory and three of eight elective courses, ranging in length from one-half day to two days. A half-day program shall be four hours in length, while a full-day program shall be seven hours. Executive directors of housing authorities must satisfactorily complete all seven mandatory courses and three elective courses within the time prescribed in N.J.A.C. 5:16-2.4(b). Six of the seven mandatory courses shall be offered through the LHA/MRA Training Program. The seventh course, Public Housing Management Certification, is available from other sources.

1. The mandatory executive director courses shall be as follows:

i. Executive Housing Management: a two-day program which includes an overview of the functions of planning, organizing, directing and controlling, with topics in time management, negotiation, conflict management and team building;

ii. Financial Management: includes budgets and their preparation, records, investment, computer software and financial statement preparation;

iii. Maintenance Management: includes budget preparation, staffing, quality control, resident involvement and insurance and liability;

iv. Procurement and Contract Management: provides a basic understanding of the differences between Federal and State mandated procedures and accepted professional practices used in PHA procurement in New Jersey, with emphasis on contract negotiation, management and administration skills and professional ethics;

v. Personnel Management: provides instruction to develop and evaluate management plans, correct personnel problems, measure performance levels and understand management by objectives;

vi. Ethics: familiarizes executive directors with New Jersey and HUD ethical standards and legal requirements for public officials; and

vii. Public Housing Management Certifications: PHM will not be offered on a regular basis as part of the LHA/MRA Training Program. To take this course, participants must contact a sponsoring organization directly. Credit will be awarded to anyone who has completed a PHM training program offered by a HUD-approved institute. To receive credit, a copy of a Certificate of Completion from the sponsoring organization must be submitted to the New Jersey Department of Community Affairs, Division of Housing, Fifth Floor, CN 806, Trenton, New Jersey 08625-0806 Attention: LHA/MRA Training Unit.

2. Elective courses for executive directors may include, but are not limited to, the following courses. Courses may be added or eliminated, as participant demand and interest dictate, and at the discretion of the Department.

i. Planning and Development of Affordable Housing;

ii. Resident Initiatives;

iii. Legal Issues;

iv. Public Relations/Communications;

v. Public Housing Management Assessment Program;

vi. Occupancy;

vii. Modernization; and

viii. Current Issues/Problems in Affordable Housing.

(d) The course curriculum for commissioners of municipal redevelopment agencies shall consist of three mandatory courses, ranging in length from one-half day to one day. A half-day program shall be four hours in length, while a full-day program shall be seven hours. Commissioners must satisfactorily complete all mandatory courses within the time prescribed in N.J.A.C. 5:16-2.4(a).

1. The mandatory commissioner courses shall be as follows:

i. Principles of Redevelopment: explores strategies for neighborhood revitalization, the planning process as related to New Jersey Municipal Land Use Law, financial and marketing issues;

ii. Skills for Commissioners: provides a broad overview of the roles and responsibilities of commissioners; and

iii. Ethics: provides an overview of public ethics.

(e) The course curriculum for executive directors of municipal redevelopment authorities shall consist of three mandatory and two elective courses, selected from the courses offered executive directors through the LHA/MRA Training Program. Executive directors of redevelopment agencies must satisfactorily complete all three mandatory courses and two elective courses within the time prescribed in N.J.A.C. 5:16-2.4(b).

1. The mandatory executive director courses shall be as follows:

i. Principles of Redevelopment: explores strategies for neighborhood revitalization, the planning process as related to New Jersey Municipal Land Use Law, financial and marketing issues;

ii. Planning and Development of Affordable Housing; and

iii. Ethics: provides an overview of public employee ethics.

(f) For any course topic, proposed activities shall accomplish the instructional objectives of the LHA/MRA Training Program and may include lecture, small group discussion, in class exercises, audio visual material and handouts.

(g) To the greatest extent possible, the course curriculum shall be designed to enhance student participation and shall be interactive. The use of New Jersey-specific materials is encouraged. Class sizes shall be limited to no more than 45 students.

5:16-2.2 Evaluation criteria

(a) The Department, or its authorized designee, shall develop evaluation procedures to assess the competency of participants completing the LHA/MRA Training Program. The evaluations shall allow participants to demonstrate competency and proficiency at the conclusion of each course.

(b) Course competency shall be measured through the administration of brief pre- and post-session evaluations for each course. The post-session evaluation shall be rated on a satisfactory/unsatisfactory basis.

1. The pre-session evaluation shall familiarize course participants and course instructors with the course material prior to the actual delivery of the course curriculum.

2. The post-session evaluation shall assess the course participant's understanding of the materials covered during the class. Questions designed by the instructor shall reinforce key concepts, important issues and significant facts. The last half-hour of each course shall be reserved for students to complete written responses to the questions. A determination of satisfactory or unsatisfactory performance in completing the evaluation shall be in accordance with the standards prescribed by the Department.

(c) To receive credit for a course, a commissioner or executive director must attend the full session and achieve a satisfactory score on the evaluation. No credit shall be assigned for a failed or incomplete course.

1. In instances where a participant attends the course but does not complete the evaluation, the participant shall receive an incomplete for the course. In order to receive credit for the course, the participant must contact the training facilitator and make arrangements to complete the evaluation within 45 days of the date of the training course. Failure to contact the training facilitator and satisfactorily complete the required evaluation shall result in the participant receiving no credit for the course.

(d) To obtain credit toward certification for a failed course, the course must be retaken and a satisfactory score achieved on the evaluation.

5:16-2.3 Certificate of completion

(a) The training facilitator shall issue a certificate of completion to each LHA/MRA Training Program participant who satisfactorily completes the training program requirements.

(b) Issuance of a certificate shall certify that the individual has completed the requisite course of study of the LHA/MRA Training Program and is eligible to be employed or appointed in the State in accordance with the provisions of these rules.

5:16-2.4 Compliance period

(a) Except as provided by N.J.S.A. 40A:12A-46(a), any person serving as a commissioner on the board of a local housing authority or municipal redevelopment agency after the effective date of the rules shall satisfactorily complete the prescribed course curriculum within one year following the date of appointment or the effective date of the rules, whichever is later.

(b) Any person serving as the executive director of a local housing authority or municipal redevelopment agency on or after the effective date of the rules shall satisfactorily complete the prescribed course of study within two years after the effective date of the rules or the effective date of his or her appointment, whichever is later. Executive directors of local housing authorities shall satisfactorily complete at least five of the requisite courses within one year of appointment, or the effective date of the rules.

(c) The Department shall award course credit to those participants who attended the approved LHA/MRA Training Program courses prior to the promulgation of these rules and allow participants to apply these credits toward the training program requirements.

5:16-2.5 Waivers

(a) The Commissioner of the Department shall waive the education and experience requirements for the executive director and the training requirements for the executive director or commissioner of a housing authority or redevelopment agency under the following circumstances:

1. The college education and experience requirements set forth in N.J.S.A. 40A:12A-18 shall be waived upon submission of a written determination of equivalency for the college education and the five years of work experience from any Department-approved equivalency agency.

i. The determination of equivalency shall clearly indicate the number of years of equivalent experience to be awarded;

ii. The determination of equivalency shall include a list of courses, by name or course title, considered in assessing educational equivalency.

2. The DCA Commissioner shall waive all or part of the Training Program course requirements set forth in N.J.S.A. 40A:12A-46 and 47 upon submission of a written determination of course equivalency from a Department-approved Equivalency Agency.

i. The determination of course equivalency shall list the courses submitted for determination and indicate to which course(s) of the LHA/MRA Training Program the course is equivalent.

5:16-2.6 Evaluation of equivalency

(a) A commissioner or executive director's experience, education and coursework shall be evaluated for equivalency credit by the Department-approved equivalency agency, provided it was acquired within three years of the request and in one of the following ways:

1. By obtaining course credits at other institutions; or

2. By completing approved license, certificate, and training programs offered by employer and professional associations.

(b) The Department-approved equivalency agency will utilize the following criteria for judging equivalency:

1. The course must have been organized and presented under the auspices of a recognized educational or professional institution;

2. The course must have included seven hours of class attendance, not counting examinations. (Independent study, video or home study courses shall not be considered);

3. Registrants in the course must have satisfactorily completed at least one written evaluation; and

4. Satisfactory completion of the course must have been based upon receiving a passing grade of 2.0 or above based on a 4.0 scale.

(c) Individuals requesting an equivalency evaluation from the Department-approved equivalency agency shall be responsible for the following:

1. Assuming all costs associated with the evaluation; and

2. Submitting a course description, official transcript or certificate of completion and other required documentation to the approved equivalency agency for review.

5:16-2.7 Right of appeal

(a) Any person aggrieved by any notice, action or order under this chapter concerning course and experience equivalency determinations, removal of a commissioner or executive director who is deemed unqualified, denials of waiver requests or imposition of any penalties, may appeal by submitting a written hearing request as set forth herein.

1. The aggrieved party must request a hearing. The request shall be made to the Hearing Coordinator, Department of Community Affairs, CN 802, Trenton, New Jersey 08625. The hearing shall be conducted by the Office of Administrative Law, with the DCA Commissioner issuing the final decision.

2. All hearing requests shall be signed by a proper party and shall include:

i. The date of the action which is the subject of the appeal;

ii. The name, title and status of the person submitting the appeal;

iii. The action claimed to be in error; and

iv. A concise statement of the basis for the appeal.

(b) Hearing requests shall not be valid unless submitted within 15 days after receipt of the ruling, notice, determination of equivalency or other similar document upon which the appeal is based.

5:16-2.8 Exemptions

(a) The executive director of a housing authority holding that position at the effective date of the Redevelopment and Housing Law, P.L. 1992, c.79 (N.J.S.A. 40A:12A-1 et seq.), possessing the required work experience and holding certification as a Public Housing Manager (PHM) from the National Association of Housing Officials, or from another HUD-recognized professional association in the housing and redevelopment field, shall not be required to meet the college education and work experience requirements of the credentialing process set forth at N.J.A.C. 5:16-3.1(a) and shall be deemed qualified for continued employment as executive director of any local public housing authority in the State. An executive director shall meet the LHA/MRA Training Program requirements, set forth in this subchapter, unless he or she obtains a written waiver of all or part of the training requirements from the Department.

1. Executive directors in position on the effective date of these rules shall have one year from the effective date of the rules to obtain a recognized PHM certification.

2. This education exemption shall apply to executive directors in position prior to the effective date of the rules.

SUBCHAPTER 3. GENERAL PROCEDURES

5:16-3.1 Employment requirements for executive directors

(a) To assure the effective management and operation of housing authorities and redevelopment agencies, N.J.S.A. 40A:12A-18

establishes that an executive director shall have attained the following educational and experience requirements:

1. A degree from an accredited four year college or university in public administration, social science or other appropriate program; and

2. At least five years' experience in public administration, public finance, realty, or similar professional employment.

i. Attainment of a masters' degree in an appropriate program may be substituted for two years of experience.

(b) To ensure that executive directors of local housing authorities and municipal redevelopment agencies satisfy the minimum requirements, the DCA Commissioner shall expeditiously review the credentials and qualifications of candidates for the position of executive director prior to appointment. The DCA Commissioner may, at his or her discretion, seek advisory input from other organizations in conducting the review.

1. The authority or agency shall submit for review the credentials of a candidate prior to an offer of employment. The candidate's resume, along with appropriate qualifications and certifications, should be sent to New Jersey Department of Community Affairs, Division of Housing, Fifth Floor, CN 806, Trenton, New Jersey 08625-0806 Attention: LHA/MRA Training Unit, Qualifications Review.

2. The DCA Commissioner shall notify the local housing authority or municipal redevelopment agency of the approval or denial of a candidate's qualifications within two weeks of receipt of the required candidate information and documentation.

(c) Appointments made in disregard of the requirements or the Department's determination that a candidate is not qualified shall constitute a violation of these rules, punishable as indicated at N.J.A.C. 5:16-3.3.

5:16-3.2 Board vacancies

(a) Six of the seven members of each local housing authority are subject to appointment by the mayor and governing body or chief executive officer of a municipality. The DCA Commissioner is empowered to fill board vacancies which remain unfilled for 120 days or more. After a vacancy has occurred for 90 days, the DCA Commissioner shall notify the governing body or chief executive officer of his or her intent to fill the vacancy. If it is not filled within the following 30 day period, the DCA Commissioner may appoint a member for the unexpired term. At the expiration of the term, the right of appointment will revert to the appointing agent.

5:16-3.3 Enforcement

(a) The Department shall take appropriate action to remove or otherwise gain compliance with the statutes or rules. This appropriate action includes, but is not limited to, issuing administrative orders or notices or instituting or causing to be instituted any necessary legal proceedings. The Department shall take such action if it determines that an executive director or commissioner of a local housing authority or municipal redevelopment agency:

1. Has obtained the LHA/MRA Training Program Certificate of Completion by fraud or misrepresentation;

2. Has fraudulently or deceitfully accepted appointment as an executive director or served as a commissioner;

3. Has failed to satisfy the minimally acceptable level of training required by these rules;

4. Has made a false or misleading written statement, or has made a material omission in any submission to the Department; or

5. Has failed to comply with any order issued by the Department.

(b) The Department, in addition or as an alternative to the actions listed in (a) above, may issue a letter of warning, reprimand, or censure with regard to any conduct that, in the judgment of the Department so warrants.

SUBCHAPTER 4. ESTABLISHMENT OF TRAINING PROGRAM

5:16-4.1 Scope; intent

(a) This subchapter shall control all matters pertaining to the organization and development of the mandatory training program for executive directors and commissioners of local housing authorities and municipal redevelopment agencies.

(b) This chapter is intended to implement the "Redevelopment and Housing Law," P.L. 1992, c.79 (N.J.S.A. 40A:12A-1 et seq.) the purpose of which includes ensuring the diligent oversight and administration of local housing authorities and municipal redevelopment agencies and providing the executive directors and commissioners of these entities with comprehensive training in topics related to the operation and management of public housing, publicly assisted housing, and redevelopment agencies. The establishment of a LHA/MRA Training Program is intended to facilitate the effective training of executive directors and commissioners.

(c) The purpose of this subchapter and of N.J.A.C. 5:16-3 are as follows:

1. To establish a LHA/MRA Training Program;

2. To require all persons assuming the position of executive director or commissioner of a local housing authority or municipal redevelopment agency to receive appropriate training, as provided in this subchapter and in N.J.A.C. 5:16-3; and

3. To establish standards and qualifications for persons serving in the capacity of executive director of a local housing authority or municipal redevelopment agency.

5:16-4.2 Applicability

(a) The provisions of this subchapter and N.J.A.C. 5:16-3 shall apply to all executive directors and commissioners of local housing authorities and municipal redevelopment agencies who are currently serving or who are appointed or employed subsequent to the effective date of these rules.

5:16-4.3 Standards for Training Program

(a) In order to competently perform their individual responsibilities and effectively enforce the "Redevelopment and Housing Law," P.L. 1992, c.79 (N.J.S.A. 40A:12A-1 et seq.) at the local level, executive directors and commissioners must be fully knowledgeable about issues affecting the redevelopment process, public and publicly-assisted housing and their residents. Financial management, construction management and code compliance, ethics and legal issues affect the effective and efficient operation of local housing authorities and municipal redevelopment agencies. This subchapter adopts standards governing the creation and implementation of the LHA/MRA Training Program.

(b) The standards for the development and administration of the course curriculum shall be prescribed and enforced by the DCA Commissioner. The course curriculum is designed to enhance the knowledge and technical and administrative expertise of executive directors and commissioners exercising policy oversight and administrative and management responsibility for the operations of local housing authorities and municipal redevelopment agencies.

(c) The course curriculum for executive directors and commissioners shall consist of a planned pattern of comprehensive educational courses and interactive case studies designed to enhance group discussion and student participation and which meet the standards set forth in N.J.A.C. 5:16-3.1 et seq.

(d) LHA/MRA Training Program courses shall be scheduled in both the spring and fall semesters in various locations throughout the State of New Jersey. A full course curriculum will be offered for at least two years after the promulgation of the rules. In subsequent years, the Department will analyze the demand for continued training, estimate potential annual enrollments and structure the availability, location and selection of courses to sufficiently address the demand.

(e) State-approved courses may be offered for accreditation by other organizations only with the express written consent of the Department. The Department shall not provide course credit to any participant who completes courses offered by an institution or organization which has not been so approved by the State at the time the course is offered.

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code Subcodes

Proposed Amendments: N.J.A.C. 5:23-3.4 and 3.18

Authorized By: Harriet Derman, Commissioner, Department of Community Affairs.

Authority: N.J.S.A. 52:27D-124.

Proposal Number: PRN 1994-631.

Submit written comments by January 18, 1995 to:

Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, New Jersey 08625-0802
FAX Number (609) 530-6729

The agency proposal follows:

Summary

On October 24, 1992, the Energy Policy Act of 1992, Public Law 102-486, was signed by President Bush. Two portions of this law dealt with the energy efficiency standards of buildings:

Residential Buildings: Within two years after the enactment of this law, each state is to certify to the Secretary of the United States Department of Energy that it has "reviewed the provisions of its residential building code regarding energy efficiency and made a determination as to whether it is appropriate for such state to revise such residential building code provisions to meet or exceed" the 1992 edition of the CABO Model Energy Code.

Commercial Buildings: Within two years after the enactment of this law, each state is to certify to the Secretary of the United States Department of Energy that the provisions of its commercial building code regarding energy efficiency meet or exceed ASHRAE 90.1-1989.

The Department undertook a comparison of the State's current energy subcode provisions with the 1992 CABO Model Energy Code and ASHRAE/IES 90.1-1989 for residential buildings and commercial buildings respectively. The Department has concluded that the current energy subcode, which is based on the 1993 BOCA National Energy Conservation Code, is less energy-efficient for residential buildings than the 1992 CABO Model Energy Code (MEC) due to the higher envelope requirements in the CABO MEC. However, cost analysis reveals that the expense to upgrade to the enhanced energy requirements of the 1992 CABO MEC is substantial and results in unacceptable simple paybacks. For example, the data shows that simple payback in energy cost savings would range from approximately eight to 24 years, with an average of 10 to 12 years for a single-family, detached housing. For attached housing, no payback can be calculated because the heating costs are higher for CABO than for BOCA. The data indicates that building envelopes that comply with CABO add between $1,076 and $2,262 to the cost of a single-family detached house with a basement over the cost of compliance with BOCA.

The Department has concluded that the requirements of the current energy subcode are less stringent than ASHRAE/IES 90.1-1989 for commercial buildings. Since the ASHRAE/IES 90.1-1989 requirements are so vastly different than the current energy subcode, the Department has determined it is not feasible to amend the technical requirements of its current adopted model energy code to meet or exceed ASHRAE/IES 90.1-1989. Therefore, as mandated by the Energy Policy Act, the Department is proposing to amend its current energy subcode to adopt by reference ASHRAE/IES 90.1-1989 for commercial buildings. Because this is a Federal mandate, no cost analysis was performed.

Since the manner in which residential and commercial buildings are categorized in the Energy Policy Act differs from the building use groups in the BOCA National Codes, changes to the current energy subcode are necessary. Residential buildings, from an energy subcode standpoint, include all Use Group R-3 and R-4 buildings, as well as Use Group R-2 buildings not over three stories in height. Commercial buildings, from an energy subcode standpoint, include all non-residential buildings, as well as Use Group R-1 buildings (hotels, motels, and other transient facilities) and all Use Group R-2 buildings over three stories in height.

In reviewing the current energy subcode provisions, the Department has determined that the definitions previously included at N.J.A.C. 5:23-3.18(b)2 are either also defined in referenced standards or are commonly-understood terms. Therefore, the Department is proposing to delete N.J.A.C. 5:23-3.18(b)2 as included in this proposal.

Further, the Department is proposing to establish at N.J.A.C. 5:23-3.18(b)2i values by counties for annual Fahrenheit heating degree days to be utilized in determining residential building thermal transmittance values. These values are based on the latest draft document prepared by Battelle, Pacific Northwest Laboratories and takes into consideration weather data obtained from the National Oceanic and Atmospheric Administration. The Department is also proposing to amend the design conditions contained in the current energy subcode to reflect values contained within the ASHRAE standards as proposed in N.J.A.C. 5:23-3.18(b)3. Energy calculation values for commercial buildings are to be determined as provided in the ASHRAE standard.

Responsibility for the enforcement of specific provisions of the ASHRAE/IES 90.1-1989 are also established in the proposed amendments to N.J.A.C. 5:23-3.4(e).

Social Impact

The proposed amendments are necessary to fulfill the State's mandate under the Federal Energy Policy Act. The general public will benefit from enhanced energy performance in commercial buildings through reduced energy consumption and reduced pollution.

Economic Impact

The proposed amendments will result in increased construction costs, for commercial buildings. However, these costs will be off-set by the reduced operating costs of buildings built to a more stringent energy code. The proposed amendments are mandated by Federal law. For residential buildings, savings will be realized in meeting the requirements of the energy subcode in 14 counties, costs will remain the same in six counties and costs will increase in one county due to the changes in heating degree days that have been proposed to more accurately reflect weather conditions across New Jersey.

Regulatory Flexibility Analysis

The proposed amendment concerning commercial properties will affect "small businesses," as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., to the same extent as it will other owners and users of commercial properties that are required to be in conformity with current provisions of the State Uniform Construction Code. This is a Federally-mandated change and there is no basis for differential treatment of small businesses. There will be no change in the professional services required or in the administrative requirements applicable to anyone doing construction.

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

5:23-3.4 Responsibility

(a)-(d) (No change.)

(e) Responsibility for enforcement of specific provisions of the energy subcode shall be as follows:

1. Chapters 3 and 4 **of the BOCA National Energy Conservation Code and Sections 8, 9, 10, and 13 of ASHRAE/IES 90.1-1989** shall be enforced exclusively by the building subcode official.

2. Chapter 5 **of the BOCA National Energy Conservation Code and Section 11 of ASHRAE/IES 90.1-1989** shall be enforced exclusively by the plumbing subcode official.

3. Chapter 6 **of the BOCA National Energy Conservation Code** [and] standard LEM-1 **and sections 5, 6, 7, and 12, of ASHRAE/IES 90.1-1989** shall be enforced exclusively by the electrical subcode official.

4.-5. (No change.)

(f)-(j) (No change.)

5:23-3.18 Energy Subcode

(a) (No change.)

(b) The following chapters **and sections** of the energy subcode are amended as follows:

1. The following amendments are made to Chapter 1 of the energy subcode entitled "Scope and Application":

i. (No change.)

ii. **The text of** Section E-101.3 is [amended to delete the last sentence] **deleted and the following language is substituted: "Buildings other than those of use group R-3 and R-4 as well as R-2 which are three stories or less in height shall meet the requirements of**

ASHRAE/IES 90.1-1989. For buildings of use group R-3, and R-4 as well as R-2 which are three stories or less in height, compliance with the applicable provisions of ASHRAE 90A or 90B listed in Chapter 8 shall be deemed to meet the requirements of this code, unless otherwise specifically provided for herein".

iii. Section E-101.4 is amended to add the words "... except for buildings and structures required to comply with ASHRAE/IES 90.1-1989 as noted in section E-101.3 "after the words" ... shall apply" in the last sentence.

[2. Chapter 2 of the energy subcode, entitled "Definitions," Section E-201—General Definitions, is amended to add the following definitions.

i. "Bin, Degree Day Methods" means—Simplified methods for calculating the heating or cooling load are treated as an instantaneous function of the difference between indoor and outdoor temperatures. The Degree Day method uses the actual temperature difference while the bin method categorizes those differences into "bins" covering a range of five degrees (e.g., from 20-25 degrees difference).

ii. "Boiler Capacity" means—The rate of heat addition in BTU/hr. (watts) measured at the boiler outlet at design temperature and pressure and rated input.

iii. "Building Envelope" means—The walls, roof and floor of a building through which heat may be transferred to or from the exterior from non-conditioned spaces. The above elements are to be considered as comprising a building envelope for all conditioned spaces that they enclose.

iv. "Cut on Temperature" means—The temperature at which a piece of mechanical equipment will automatically begin operation.

v. "Design Parameters" means—The conditions of temperature and humidity which form the basis for the mechanical system design.

vi. "Dry Bulb Temperature" means—The atmospheric temperature as indicated by an ordinary thermometer.

vii. "Dual Duct/Multi-Zone Systems" means—Mechanical systems in which the entering air is divided into two flows. The first is heated to the highest temperature required in the building. The other stream is cooled to the lowest temperature anywhere in the building. These two air streams are then mixed in varying proportions to provide the correct air temperature for each zone of the building.

viii. "Economizer Cycle" means—The use of uncooled outside air for cooling purposes when it will result in an energy savings.

ix. "Enthalpy" means—The mount of internal energy (heat) in a mixture of air and water vapor.

x. "Fenestration" means—The window area of the wall.

xi. "Latent Heat" means—Heat which does not change the temperature of substance but which changes its state. That is, latent heat addition could change a solid to a liquid or a liquid to a gas. Latent heat removal could change a gas to a liquid or a liquid to a solid.

xii. "97½ percent temperature" means—The hourly temperature which is exceeded 97½ percent of the time during a year. That is, it is colder than this only 2½ percent of the time.

xiii. "Overall Thermal Transmittance Value (OTTV)" means—A measure of heat transmission for cooling purposes measured in units of BTU/hr. transferred through a one square foot area of a substance in the cooling season.

xiv. "Part Load Profile" means—The compilation of operating characteristics of a piece of mechanical equipment when operated over the ranges from zero to full load.

xv. "Power Factor" means—The proportion of total power in an electrical circuit which is available as usable energy.

xvi. "Recooling Systems" means—Mechanical systems which heat all entering air to the highest temperature required anywhere in the building. The air is then recooled to the temperature necessary for other parts of the building.

xvii. "Recovered Energy" means—Energy utilized which is obtained by recovery of useful energy from other mechanical devices in the building which would otherwise be wasted.

xviii. "Relative Humidity" means—The ratio of the amount of water vapor in the air to the maximum amount of water vapor the air can hold at that temperature.

xix. "Sensible Heat" means—Heat which changes the temperature of a substance when added or removed.

xx. "Source Energy" means—The energy obtained from a given source such as electricity, oil, gas, solar, etc.

xxi. "Spill Light" means—Light which illuminates an area for which it is not intended or needed.

xxii. "Standby Loss" means—The amount of energy lost from a system over a period of time when there is no demand placed on it for energy.

xxiii. "TDEQ (Equivalent Temperature Difference)" means—A temperature to be utilized in calculating the design load for cooling systems. It is designed to account for the lag in wall temperature use due to the mass of the walls. Heavier walls heat up more slowly.

xxiv. "2½ percent temperature" means—The hourly temperature which is exceeded 2½ percent of the time during a year. That is, it is cooler than this 97½ percent of the time.

xxv. "Veiling Reflection" means—A reflected glare which obscures vision and reduces ability to see details.

xxvi. "Wet Bulb Temperature" means—A temperature which reflects the amount of moisture which may be evaporated into the atmosphere. When the relative humidity is 100 percent, the dry bulb temperature is equal to the wet bulb temperature. When the relative humidity is lower, moisture can evaporate into the atmosphere, thus cooling a thermometer. The greater the difference between the wet and dry bulb temperatures, the dryer the air.]

[3.]**2.** The following amendments are made to Chapter 3 of the energy subcode entitled "Building Envelope":

i. Section E-302.1 is amended to delete the words "or the CABO Model Energy Code" and to add the [words "In all municipalities of the State of New Jersey, thermal transmittance values shall be determined using the figure of 5,500 annual Fahrenheit heating degree days."] **following sentences: "For determining required thermal transmittance values for buildings of use groups R-3, R-4 and R-2 that are three stories or less in height, the following heating degree day values shall be used for the following counties:**

(1) 4,500 annual Fahrenheit heating degree days shall be used for the counties of Cape May, Salem, Cumberland, Camden, Atlantic and Gloucester.

(2) 5,000 annual Fahrenheit heating degree days shall be used for the counties of Burlington, Ocean, Monmouth, Mercer, Middlesex, Essex, Hudson and Union.

(3) 5,500 annual Fahrenheit heating degree days shall be used for the counties of Somerset, Warren, Hunterdon, Morris, Bergen and Passaic.

(4) 6,000 annual Fahrenheit heating degree days shall be used for the county of Sussex."

[4.]**3.** The following amendments are made to Chapter 4 of the energy subcode entitled "Heating, Ventilating and Air Conditioning Systems and Equipment":

i. Delete section E-402.1.1 and substitute the words "Design temperatures shall be as follows: Winter [14°F.] **six degrees F.**; Summer DB 90°F.; Summer WB 76°F.".

Recodify existing 5.-8. as **4.-7.** (No change in text.)

[9.]**8.** The following amendments are made to section 2 of standard LEM-1 of the energy subcode, entitled "Scope":

i. Delete the first paragraph in the section and in lieu thereof, substitute "These provisions regulate the amount of power which may be utilized by [a] buildings **of use group R-3 and R-4 as well as R-2 which are three stories or less in height** for lighting. No **such** building shall employ more power for lighting than that determined through the use of the criteria and calculated procedures contained herein."

(c) (No change.)

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code
Abandonment of Septic Systems
Proposed Amendment: N.J.A.C. 5:23-3.15

Authorized By: Harriet Derman, Commissioner, Department of Community Affairs.
Authority: N.J.S.A. 52:27D-124.
Proposal Number: PRN 1994-644.

Submit comments by January 18, 1995 to:
Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, New Jersey 08625-0802
FAX No. (609) 633-6729

The agency proposal follows:

Summary

Together with a counterpart amendment to N.J.A.C. 7:9A-12.8 proposed by the Department of Environmental Protection at 26 N.J.R. 2715(a), and adopted at 26 N.J.R. 3829(a), the proposed amendment to N.J.A.C. 5:23-3.15(b) makes clear the allocation of inspection responsibility, in cases of septic systems abandonment, between officials enforcing the plumbing subcode of the State Uniform Construction Code and local health officers enforcing DEP rules.

Both the State Uniform Construction Code (N.J.A.C. 5:23) and the Rules for Individual Subsurface Disposal Systems (N.J.A.C. 7:9A) contain requirements for abandoning septic systems, but there is currently no clear demarcation line between the jurisdictions of the officials responsible for the enforcement of the two sets of rules. This has resulted in duplication of effort and, in some instances, conflicting orders being given to property owners.

Since a construction permit is required when a connection to a public sewer is to be made, it would be most efficient to have the plumbing subcode official determine whether the existing septic system is properly abandoned. However, in those cases where no work for which a construction permit is required is being done, and the inspection is therefore limited to the septic system being abandoned, only the health officer should be involved.

Social Impact

The proposed amendment will have the beneficial effect of eliminating redundant inspections and thus avoiding potential confusion due to conflicting orders. Property owners will no longer have the burden of having to call two offices for inspections for the same purpose.

Economic Impact

This amendment, together with the DEP counterpart amendment, will benefit property owners by eliminating the need to pay fees for redundant inspections. Time lost in waiting for inspections will be substantially reduced because fewer inspections will be required.

Regulatory Flexibility Statement

This proposed amendment will benefit all affected property owners and will not impose any compliance requirements, whether on "small businesses," as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., or on others.

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

5:23-3.15 Plumbing subcode

(a) (No change.)

(b) The following pages, chapters, sections or appendices of the plumbing subcode are amended as follows:

1.-15. (No change.)

16. [Chapter] **Except as otherwise indicated in (b)16i below, sections 16.1 through 16.12.1.13 of chapter** 16 of the plumbing subcode, entitled "Regulations governing individual sewage disposal systems for homes and other establishments where public sewer systems are not available" [and comprising sections 16.1 through 16.12.1.3, is] **are** deleted in [its] **their** entirety.

i. Section 16.1.7 is retained and amended to read as follows: "When a sewage disposal system is being abandoned and a connection is being made to the public sewer system, the plumbing subcode official shall ensure that the abandoned septic system is disconnected from the building, pumped out and filled with gravel, stones or soil material."

Note: Existing standards of the Department of Environmental Protection [and Energy] and boards of health with respect to individual on-site sewage disposal systems remain in effect.

17.-19. (No change.)

(b)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code
Mechanical Subcode
Proposed Amendment: N.J.A.C. 5:23-3.20

Authorized By: Harriet Derman, Commissioner, Department of Community Affairs.
Authority: N.J.S.A. 52:27D-124.
Proposal Number: PRN 1994-642.

Submit written comments by January 18, 1995 to:
Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, New Jersey 08625-0802
Fax No. (609) 633-6729

The agency proposal follows:

Summary

In accordance with the agency note that appeared with the December 20, 1993 adoption notice at 26 N.J.R. 5918(a) of the 1993 BOCA Mechanical Code, the Department has retained the indoor air quality subcode, N.J.A.C. 5:23-3.20A. This subcode incorporates the standard known as ASHRAE 62-1989.

This amendment deleting and amending certain portions of chapter 16 of the 1993 BOCA National Mechanical Code is necessary to ensure the technical consistency of the mechanical subcode with the retained indoor air quality subcode. The Department found the retention of ASHRAE 62-1989, in lieu of conflicting requirements in the 1993 BOCA National Mechanical Code, to be appropriate because ASHRAE 62-1989 generally allows recirculation of heated or cooled air, thereby allowing greater energy efficiency while still providing adequate indoor air quality. Recirculation of air is not allowed in areas of a building in which foul odors or pollutants are likely to be generated. A technical amendment to section M-1605.1 of the mechanical subcode is proposed at N.J.A.C. 5:23-3.20(b)7 to maintain this limitation on recirculation that the BOCA National Mechanical Code establishes by reference to a note in Table M-1604.3, a table being deleted by this proposal because of its inconsistency with the indoor air quality subcode.

Social Impact

The proposed amendment will eliminate a possible source of confusion for design professionals and builders by deleting a set of requirements that conflicts with other requirements that are in effect.

Economic Impact

By making it clear that it is the ASHRAE 62-1989 standard, and not the unamended chapter 16 of the BOCA National Mechanical Code, that is applicable to construction under the State Uniform Construction Code, the proposed amendment will make clear the applicability of requirements that allow greater energy efficiency and consequent cost savings.

Regulatory Flexibility Statement

The elimination of a discrepancy between two rules in favor of the rule that allows energy efficiency will be beneficial to owners and users of buildings that are "small businesses," as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16, et seq., as well as to those that are not. As no requirements are increased, a regulatory flexibility analysis is not required.

Full text of the proposal follows (additions indicated in boldface **thus**):

5:23-3.20 Mechanical subcode

(a) (No change.)

(b) The following chapters, sections or pages of the BOCA National Mechanical Code/1993 are amended as follows:

1.-6. (No change.)

7. Chapter 16 of the mechanical subcode entitled "Ventilation Air" is amended as follows:

i. Section M 1604.0 is deleted in its entirety and substitute in lieu thereof "Requirements for ventilation air shall be as set forth in N.J.A.C. 5:23-3.20A".

ii. Section M-1605.1 is amended to delete the words "spaces designated by Note b of Table M-1604.3" and replace them with the words "smoking lounges; autopsy rooms; bathrooms of hotels, motels and dormitories; garages common to multiple dwelling units; public restrooms; and locker and dressing rooms".

Recodify existing 7.-10. as **8.-11.** (No change in text.)

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code Interpretations

Proposed Repeal: N.J.A.C. 5:23-9.4

Authorized By: Harriet Derman, Commissioner, Department of Community Affairs.

Authority: N.J.S.A. 52:27D-124.

Proposal Number: PRN 1994-645.

Submit comments by January 18, 1995 to:

Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, New Jersey 08625
FAX No. (609) 633-6729

The agency proposal follows:

Summary

In the 1993 Edition of the Building Officials and Code Administrators (BOCA) National Building Code, which is currently in effect as the building subcode of the State Uniform Construction Code, there is new text regarding earthquake loads. This text contains requirements for building analysis and structural material design based on recommendations from the 1991 National Earthquake Hazard Reduction Program (NEHRP) prepared by the Building Seismic Safety Council (BSSC) for the Federal Emergency Management Agency (FEMA). These provisions provide improved criteria for design and construction of buildings subject to earthquake motion, minimize the earthquake hazard for all buildings, increase the expected performance of higher-occupancy buildings as compared to ordinary buildings, and improve the capability of essential facilities to perform during and after an earthquake.

The concept of seismic zones has been deleted and is not reflected on the new contour maps since design and construction requirements are now a function of Seismic Performance Categories. Previously, a location was considered to be in either one seismic zone or another, with certain requirements either applicable or not applicable, depending on that determination.

Now, the Seismic Performance Category classification includes consideration of the seismicity of the site and the nature of the building occupancy. An additional contour map of effective peak acceleration (Aa) has been added for clarity and provides an alternative calculation procedure in lieu of utilizing the effective peak velocity-related acceleration (Av) coefficient. Because the maps in the BOCA National Building Code are drawn at a scale that makes it difficult to determine precisely where the borders between the interpolated areas are, the Department is proposing to repeal N.J.A.C. 5:23-9.4 containing the current interpretation on the basis of the data used by BOCA. The Department believes the current data is sufficient to allow design professionals to derive reasonable interpolated values for both the Av and Aa coefficients.

Social Impact

The proposed repeal is not expected to have any social impact. The new text within the building subcode provides sufficient guidance to ensure protection of life safety in buildings subject to seismic activity.

Economic Impact

To the extent that the new text in the building subcode would require a different degree of seismic protection at any particular location, a building to be constructed in that location might be subject to either more restrictive or less restrictive requirements.

Regulatory Flexibility Statement

The purpose of the proposed repeal is to protect the safety of building occupants by assuring that the most appropriate seismic standards are in effect in all parts of New Jersey. Different seismic standards cannot be applied for properties owned or occupied by "small businesses," under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., as opposed to other entities, since earthquakes, when they occur, do not recognize such distinctions.

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

5:23-9.4 [Seismic Zones] **(Reserved)**

[(a) Based on the building subcode (BOCA National Building Code), the State of New Jersey is divided into two seismic zones roughly dividing the State along a northeast-southwest diagonal and thereby creating a northern and southern region.

1. Seismic Zone 1 shall consist of and include the counties of Monmouth, Ocean, Burlington, Camden, Gloucester, Salem, Cumberland, Atlantic and Cape May.

2. Seismic Zone 2 shall consist of and include the counties of Sussex, Warren, Morris, Passaic, Bergen, Hudson, Essex, Union, Somerset, Hunterdon, Mercer and Middlesex.

(b) The Department, for reasons of administrative convenience and in order to avoid non-uniform interpolation, has established the following county-wide designations of seismic zones and effective peak velocity-related acceleration (A_v) to enable design professionals to determine easily what requirements shall be met in each municipality.

1. Seismic Zone 1:
i. Monmouth: .095;
ii. Burlington and Ocean: .080;
iii. Camden: .075;
iv. Gloucester: .070;
v. Salem and Atlantic: .060;
vi. Cumberland and Cape May: .050.
2. Seismic Zone 2:
i. Sussex: .125;
ii. Warren, Morris, Passaic and Bergen: .102;
iii. Essex: .115;
iv. Hunterdon, Somerset, Union and Hudson: .110;
v. Mercer and Middlesex: .105.

(c) The zone requirements established in (a) above shall apply both to the mechanical design and to the building structural system. The A_v values established in (b) above shall be utilized when calculating lateral seismic forces for structural design.]

HEALTH

(b)

DIVISION OF HEALTH PLANNING AND RESOURCES DEVELOPMENT

Certificate of Need: Megavoltage Radiation Oncology Services

Proposed Readoption with Amendments: N.J.A.C. 8:33I

Authorized By: Len Fishman, Commissioner, Department of Health (with approval of the Health Care Administration Board).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.
Proposal Number: PRN 1994-662.

Submit comments by January 18, 1995 to:
John J. Gontarski, Acting Director
Health Planning and Community Initiatives
New Jersey Department of Health
CN 360, Room 604
Trenton, New Jersey 08625-0360

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 8:33I expires on February 16, 1995. The Department of Health has reviewed the rules and, with minor technical amendments, has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated, as required by the Executive Order. The Department does intend to continue to review these rules as part of an overall regulatory reform program that is currently underway and may very well develop substantive amendments to these rules in the future.

On October 6, 1977, the Department of Health established rules to govern the planning and certification of need requirements for regional megavoltage radiation oncology services. Following a comprehensive statewide planning effort based on the megavoltage rules established at N.J.A.C. 8:33I, a system of regionalized megavoltage radiation oncology services was established. This effort involved the development of regional programs (34 programs with 54 megavoltage units Statewide) to provide appropriate volumes of treatment services at each site in order to maintain the proficiency of the treatment team and to advance the quality and cost effectiveness of each program.

This proposed readoption includes technical amendments that reflect changes in the Department's regulatory authority that has occurred as a result of the promulgation of the Health Care Cost Reduction Act (P.L. 1991, c.187) and the Health Care Reform Act (P.L. 1992, c.160). The amendments being proposed at this time (at N.J.A.C. 8:33I-1.3(a)2 and (b)5 and 6) remove outdated language related to the Hospital Rate-Setting Commission, which no longer exists. The definition of "medium/high energy" is being clarified to limit the 20 megavolt unit to a single equipment category, at N.J.A.C. 8:33I-1.1(b). The timing of the Statewide megavoltage data to be used to determine the extent that existing equipment is being utilized is also being modified at N.J.A.C. 8:33I-1.4(a), 1.3(a)1, and 1.3(b)1 to permit the most recent data available at the Department of Health to be used in the review process. A new requirement is being added at N.J.A.C. 8:33I-1.3(a)3 that reinforces the licensing requirement that all megavoltage radiation services must have on-site simulation capability. In addition, existing licensing requirements for personnel are incorporated in the rules (at N.J.A.C. 8:33I-1.5) including an added requirement for a professional social worker, at N.J.A.C. 8:33I-1.5(a)5, and the deletion of the requirement for a simulator technician, which can be fulfilled by the radiotherapy technicians that are already required at N.J.A.C. 8:33I-1.5(a)3. A new requirement is also being added at N.J.A.C. 8:33I-1.4(c)10, which requires documentation showing that applicants are actively involved in cancer disease prevention and health promotion activities throughout their service area.

The purpose of the rules continues to be the establishment of a basis for the Department of Health, the State Health Planning Board, and the Local Advisory Boards (LABs) to:

1. Promote delivery of the highest quality of care to all patients requiring megavoltage radiation oncology services;
2. Maximize utilization of highly trained megavoltage radiation oncology treatment personnel, equipment, and facilities;
3. Promote cost effectiveness throughout the system; and
4. Emphasize a coordinated, cooperative and multi-disciplinary approach to megavoltage radiation oncology services.

The proposed readopted rules establish minimum criteria for the initiation, retention, or expansion of megavoltage radiation oncology services. The rules seek to promote megavoltage services that contain multiple units that are capable of providing a full range of photon and electron beam energies, as opposed to the promotion of multiple single unit programs in the State. The rules also prohibit the establishment of new megavoltage programs in the absence of demonstrated need, in an effort to encourage multiple unit services statewide and to discourage the unnecessary proliferation and duplication of services which would generate unwarranted additional costs to payers of health care.

The proposal retains the requirements that establish the parameters for consideration of the need to expand, replace or initiate megavoltage radiation oncology equipment and services at N.J.A.C. 8:33I-1.4. Minimum staffing (N.J.A.C. 8:33I-1.5), equipment (N.J.A.C. 8:33I-1.3), physical plant (N.J.A.C. 8:33I-1.6(a)1), support service (N.J.A.C. 8:33I-1.4(c)5), and data reporting (N.J.A.C. 8:33I-1.6(a)8) requirements are also being retained in this readoption in order to assure the proper operation of an effective and efficient regional megavoltage radiation oncology service.

The Department views this proposed readoption as intending to reaffirm the regional nature of this service and also serving to guide the consideration of new, expanded or replacement megavoltage services through the state's certificate of need process. The proposal also permits consideration of any possible problems of access to this service, which may be present in a limited number of areas in the State.

Social Impact

N.J.S.A. 26:2H-1 (as amended) recognizes as "public policy of the State that hospitals and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of inhabitants of the State, promote the financial solvency of hospitals and similar health care facilities and contain the rising cost of health care services, the State Department of Health . . . shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and health care services, and health facility cost containment programs. . . ."

The health care planning literature recognizes the underutilization of inpatient beds, specialty services, and expensive equipment as an important factor contributing to the rapidly escalating costs of health care. Regionalization of specialty services and equipment is viewed as an important mechanism for promoting health by improving the capabilities of services and quality of care offered, by assuring an adequate patient volume for providers offering these expensive services, and by containing the rising costs of health care services.

The Department believes the rules being proposed for readoption will continue to be effective in addressing their established goal of promoting appropriate access to a high quality of care for oncology patients in a cost effective manner.

Economic Impact

The rules were established to address both quality of care, access, and cost-effectiveness goals. Through implementation of similar regional policies in the past, high-cost megavoltage radiation oncology services of high quality have been effectively provided in New Jersey. The economic impact of these rules has thus been to produce cost efficiencies in the system of megavoltage oncology services through improving utilization of high-cost services and in avoiding unnecessary duplication of services.

The rules would limit additional megavoltage oncology programs unless there is documentation of sufficient unmet need to warrant the initiation of an efficient new megavoltage service which can achieve the required patient volumes without negatively impacting existing providers in the region.

The rules being proposed for readoption should reduce the likelihood that megavoltage programs would be permitted to proliferate at separate individual sites, thereby reducing the cost inefficiencies inherent in providing similar services at multiple sites. It is the Department's position that the provision of a wide range of megavoltage services at a single site improves the overall cost effectiveness of providing these services and promotes a comprehensive approach to patient care which is in the best interest of patients. The comprehensive nature of such a service would also facilitate a providers negotiations with managed care providers, who are seeking a full range of oncology treatment services at an affordable cost to payers.

Regulatory Flexibility Statement

Facilities affected by these rules consist largely of hospitals with more than 100 beds. These hospitals typically employ well over 100 full-time employees. It is possible, however, that smaller entities that are not specifically affiliated with hospitals will be considered as megavoltage radiation oncology providers under these rules. The requirements contained in these rules do require personnel to perform a limited number of recordkeeping and reporting functions. Such requirements do not necessitate the dedication of additional non-clinical staff and should not be considered overly burdensome to the applicants that might be considered small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

In proposing these rules, the Department has had to balance the economic impact of added personnel costs with the need to provide a safe and effective health care service. The Department has determined that to minimize the economic impact of this proposed rule would endanger public health and safety and, therefore, no exception from coverage is provided.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 8:33.

Full text of the proposed amendments follow (additions indicated in boldface **thus**; deletions indicated by brackets [thus]):

8:33I-1.2 Definitions

(a) (No change.)

(b) "Energy levels" of megavoltage units shall be defined as follows:

1. (No change.)

2. Medium/high energy—means greater than six MV X-ray or MeV electron energy **up** to 20 MV X-ray or MeV electron energy.

3. (No change.)

8:33I-1.3 Utilization of megavoltage units and programs

(a) Single unit megavoltage programs shall be subject to the following:

1. Minimum annual utilization for megavoltage unit replacement in single unit megavoltage programs is 300 total patients or 6,200 patient visits. Consideration of minimum utilization standard compliance will take into account the output of Cobalt 60 devices and the age of the equipment. Compliance with these minimum standards will be based on the actual utilization of each megavoltage unit for the **most recent** calendar year **reported to the Department** immediately prior to the [submission of the] **Commissioner's call for** certificate of need applications to replace the equipment.

2. Failure to achieve an average minimum utilization as defined in (a)1 above during any 36 consecutive months [may result in a recommendation for denial of reimbursement for the service by the Department to the Hospital Rate-Setting Commission and] shall form a sufficient basis for the Commissioner to delicense the service.

i. (No change.)

3. Single unit megavoltage programs shall have on-site simulation capability, in accordance with State licensing requirements at N.J.A.C. 8:43G-28.18.

(b) Multiple unit megavoltage programs shall be subject to the following:

1. Applicants for a second megavoltage unit at an existing megavoltage program shall document minimum acceptable annual utilization level (on its existing unit) of 9,000 actual patient visits or 500 actual patients and project the achievement of 10,500 patient visits and 600 patients within two years of installation of the second megavoltage unit. Compliance with these minimum utilization standards will be based on the actual utilization of each megavoltage unit for the **most recent** calendar year **reported to the Department** immediately prior to the [submission of the] **Commissioner's call for** certificate of need applications to replace the equipment.

2.-3. (No change.)

4. Applicants for a third megavoltage unit at an existing multiple unit megavoltage program shall meet a minimum acceptable annual utilization level (on its existing two units) of 16,000 actual patient visits or 900 actual patients. Compliance with these minimum utilization standards will be based on the actual utilization of each megavoltage unit for the **most recent** calendar year **reported to the Department** immediately prior to the [submission of the] **Commissioner's call for** certificate of need applications [to replace the equipment].

5. Failure to achieve projected minimum utilization as defined in (b)1 above, within three years of installation of the additional megavoltage equipment, [may result in a recommendation for denial of reimbursement for the service by the Department to the Hospital Rate-Setting Commission and] shall form a sufficient basis for the Commissioner to delicense the service.

6. Multiple unit programs failing to achieve an averge annual minimum utilization level as defined at (b)1 or (b)4 above, whichever is applicable, during any period of 36 consecutive months [may result in a recommendation for denial of reimbursement for the service by the Department to the Hospital Rate-Setting Commission and] shall form a sufficient basis for the Commissioner to delicense the service.

8:33I-1.4 Megavoltage Radiation Oncology Resource Allocation Policy

(a) The Department of Health will process certificate of need applications for new Radiation Oncology Programs consistent with the provisions of the Certificate of Need Policy Manual (N.J.A.C. 8:33) and only from local advisory board regions where all existing licensed Radiation Oncology Programs meet minimum annual levels of utilization as specified at N.J.A.C. 8:33I-1.3. In addition, the annual patient treatment capacity levels for existing and approved megavoltage equipment must exceed 90 percent for the **most recent** calendar year **reported to the Department of Health** prior to the Commissioner's call for certificate of need applications for new services pursuant to N.J.A.C. 8:33-4.1(a).

1. (No change.)

(b) No more than one new radiation oncology program shall be approved in each local advisory board region as defined at N.J.A.C. 8:33I-1.2, where all existing megavoltage radiation oncology programs are operating at **least at** minimum levels of utilization as specified of N.J.A.C. 8:33I-1.3. Additional new facilities will be considered only when both existing and approved facilities in a given local advisory board region are operating at minimum levels of utilization as specified at N.J.A.C. 8:33I-1.3.

(c) Applications for new and additional radiation oncology programs in a health service area will be evaluated on the basis of their ability to meet the standards established in this subchapter. In addition, the following factors will also be considered in the review process:

1.-7. (No change.)

8. Evidence that the proposed service is compatible with overall health planning goals and recommendations for the State as identified in the State Health Plan and for the local advisory board area; [and]

9. Evidence that barriers to access to care do not exist, including access to cancer screening and detection programs, and that if no barriers exist, that access to care will remain constant or improve for individuals in the service area[.]; **and**

10. Evidence that the applicant has participated in cancer disease prevention and health promotion activities throughout the communities to be served by this proposed regional cancer treatment service. Applicants shall document specific programs, targeted populations, and the frequency, duration and volume of participation for these disease prevention and health promotion activities.

(d) (No change.)

(e) All certificate of need applications for new megavoltage radiation oncology programs shall document the ability of the applicant to meet the minimum standards and criteria contained in this subchapter within three years from the initiation of the service. The inability to achieve minimum utilization levels during the third year of operations or thereafter will form a sufficient basis for the Commissioner to delicense the service [and/or recommend reimbursement sanctions] as specified at N.J.A.C. 8:33I-1.3(a)2, (b)5 and (b)6.

8:33I-1.5 Personnel standards

(a) Each applicant for a certificate of need for a megavoltage radiation therapy unit shall provide the Department with written documentation that the following minimal staff complement shall be available:

1. [One full-time equivalent] **A** radiation therapist directing radiation therapy for each program **in accordance with State licensing requirements at N.J.A.C. 8:43G-28.14(a)**.

i. (No change.)

2. Adequate coverage [in single unit programs] by a qualified radiological physicist to insure that Cobalt-60 units and other energy units are calibrated and employed properly in keeping with the volume of patients **in accordance with State licensing requirements at N.J.A.C. 8:43G-28.14(d)**. [In multiple unit programs, one full-time equivalent qualified radiological physicist is required.]

i. (No change.)

3. [Two full-time equivalent radiotherapy] ***Radiotherapy*** technicians (licensed by the State of New Jersey in accordance with N.J.S.A. 26:2D-24 et seq. and N.J.A.C. 7:28-19) **shall be available in accordance with State licensing requirements at N.J.A.C. 8:43G-28.14(c)**;

4. [One full-time equivalent nurse is required in multiple unit programs] **A registered professional nurse shall be available in accordance with State licensing requirements at N.J.A.C. 8:43G-28.14(e)**; and

5. [One full-time equivalent simulator technician is required in multiple unit programs.] **A professional member of the social work department shall be available to meet the psychosocial needs of radiation therapy patients and families, in accordance with State licensing requirements at N.J.A.C. 8:43G-28.14(f).**

HIGHER EDUCATION

(a)

COMMISSION ON HIGHER EDUCATION

Rules and Procedures for Implementation of the Higher Education Equipment Leasing Fund Act

Proposed Recodification with Amendments: N.J.A.C. 9:17 to N.J.A.C. 9A:14

Authorized By: Commission on Higher Education, Joseph D. Williams, Chair.
Authority: N.J.S.A. 18A:72A-40 and P.L. 1993, c.136.
Proposal Number: PRN 1994-650.

Submit comments by January 18, 1995 to:
Dr. Jeanne Oswald
Administrative Practice Officer
Commission on Higher Education
20 West State Street
CN 542
Trenton, New Jersey 08625

The agency proposal follows:

Summary

On June 5, 1993, P.L. 1993, c.136 was enacted. The law establishes a higher education equipment leasing fund in the New Jersey Educational Facilities Authority. The act authorizes the Authority to issue bonds in a total outstanding principal amount of $100,000,000 to finance the purchase of scientific, engineering, technical, computer, communications, and instructional equipment for lease to New Jersey public and independent institutions of higher education. The Authority may enter into lease agreements with institutions to finance the acquisition of such equipment by the institutions.

Rules effective February 22, 1994 were promulgated that required the Board of Higher Education to approve all Equipment Leasing Fund purchases before the execution of a lease agreement between the college or university and the Authority. Technical amendments to N.J.A.C. 9:17 are proposed to reflect the Higher Education Restructuring Act of 1994, which abolished the Board and Department of Higher Education and the position of Chancellor of Higher Education while creating a new entity, the New Jersey Commission on Higher Education. A brief summary of the affected sections follows:

N.J.A.C. 9:17-1.2 consists of definitions pertinent to the rules; deleted is the reference to the Chancellor of Higher Education and added are definitions of the Commission on Higher Education and the Chair and Executive Director of the Commission. The term "Board" is redefined to indicate it refers to the former State Board of Higher Education.

N.J.A.C. 9:17-1.3 delineates the process for purchasing equipment under the Higher Education Equipment Leasing Fund and specifies the information that must be included in proposals. One reference to the "Chancellor" is replaced with "Executive Director", and another, with "Commission"; references to the "Board" are replaced with either "Commission" or "or Commission", depending on whether the section concerns actions after or before July 1, 1994, the effective date of the Higher Education Restructuring Act; also, a verb tense is changed to further distinguish past from prospective action, and several typographical errors are corrected.

N.J.A.C. 9:17-1.4 delineates how the principal and interest on bonds will be paid and specifies action that will be taken if an institution fails to pay the appropriate amounts due to the Authority; the one reference to the "Chancellor" is replaced with "Commission."

N.J.A.C. 9:17-1.5 delineates the allocation of the first $100 million among the sectors and specifies how future allocations and reallocations will be determined. The section also specifies how priority areas for the use of funds for emerging needs programs will be established. In one reference, "Chancellor" is replaced with "Executive Director" and, in two others, with "Chair"; all references to the "Board" are replaced with "Commission"; also, two typographical errors are corrected.

N.J.A.C. 9:17-1.6 summarizes reporting requirements for the Authority; all references to the "Board" are replaced with "Commission."

In addition, the entire chapter is being recodified from N.J.A.C. 9:17 to 9A:14 to distinguish it from rules that were formerly under the jurisdiction of the Board/Department of Higher Education and in accordance with changes in the statutory responsibilities of the State-level higher education agency.

Social Impact

The Higher Education Restructuring Act of 1994 abolished the Board and Department of Higher Education and the position of Chancellor of Higher Education, while creating a new entity, the New Jersey Commission on Higher Education. The proposed technical amendments are necessary to align regulatory language with the new structure created by the statute.

Economic Impact

The proposed amendments have no discernible economic impact; they are necessitated entirely by statutory changes in the governance/coordinating structure for the New Jersey system of higher education, as delineated in the Higher Education Restructuring Act of 1994.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendments do not impose reporting, recordkeeping, or other compliance requirements on small business as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules apply only to colleges and universities none of which qualify as a small business as that term is defined by the Act.

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

(**OAL Note:** N.J.A.C. 9:17 is recodified as N.J.A.C. 9A:14.)

CHAPTERS 1 THROUGH 13. (RESERVED)

CHAPTER [17]**14**
RULES AND PROCEDURES FOR IMPLEMENTATION OF THE HIGHER EDUCATION EQUIPMENT LEASING FUND ACT

[9:17-1.1] **9A:14-1.1** (No change in text).

[9:17-1.2] **9A:14-1.2** Definitions

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

...

"Board" means **the former** State Board of Higher Education.

...

"Chair" means Chair of the Commission on Higher Education.

["Chancellor" means the Chancellor of Higher Education.]

"Commission" means the Commission on Higher Education.

"Emerging needs program" means a degree program, function or activity at one or more public or private institutions of higher education directed to meeting new and advanced technology needs within an existing academic program, or to support new academic programs in science and technology or to support new instructional technologies, as solely determined by the [Board] **Commission.**

...

"Executive Director" means Executive Director of the Commission on Higher Education.

...

[9:17-1.3] **9A:14-1.3** Process for purchase of higher education equipment

(a) Upon approval by the governing board of an institution or an entity authorized to act on their behalf, participating institutions shall propose equipment purchases to the [Board] **Commission** to be acquired with the proceeds of bonds. No proposal shall be for an amount less than 25 percent of the respective institution's total allocation pursuant to N.J.A.C. [9:17-1.5] **9A:14-1.5** or $1,000,000, whichever is less, unless it is for the final portion of its allocation. Proposals shall include information concerning:

1.-6. (No change.)

7. The source of revenue to pay the institution's annual share of principal and interest [of] **on** bonds issued to acquire equipment for use by the institution; and

8. Other information as may be required by the [Chancellor] **Executive Director** on a case by case basis and relating to a specific proposal.

(b) Proposals shall be submitted in a format provided by the [Chancellor] **Commission**.

(c) Descriptions of the equipment submitted in the proposal may be illustrative, and the equipment to be purchased may be changed as a result of the bidding processes, advances in technology, or for other reasons provided that the equipment [is] **had been** approved by the governing board of the affected institution and **by** the Board **(for transactions before July 1, 1994) or Commission**.

(d) Equipment to be purchased must be approved at a public meeting of the [Board] **Commission.**

(e) The total dollar amount of purchases approved for any institution shall not exceed the institution's allocation as approved by the Board **(for allocations made before July 1, 1994) or Commission**.

(f) The [Board] **Commission** shall forward to the Authority requests for equipment approved by [Board] **Commission** resolution.

(g) Lease agreements with institutions for the lease-purchase of equipment approved by the [Board] **Commission** shall require the respective institution to pay to the Authority 25 percent of the principal and interest on the bonds to be issued to finance the equipment purchase for the respective institution.

(h)-(k) (No change.)

[9:17-1.4] **9A:14-1.4** Payment of principal and interest

(a)-(c) (No change.)

(d) If an institution fails or is unable to pay to the Authority in full, when due, any such obligation of an institution to the Authority, an amount sufficient to satisfy the deficiency shall be retained by the State Treasurer from State aid or an appropriation payable to the institution. As used in this section, "obligation of an institution" means any amount payable by the instituion under a lease agreement to meet principal and interest on the bonds issued to acquire equipment for the institution under this program. The Authority shall notify the State Treasurer of the amount to be retained to satisfy the obligation of each institution. A copy of such notification shall be submitted to the [Chancellor] **Commission**.

[9:17-1.5] **9A:14-1.5** Allocation of funds

(a) (No change.)

(b) The [Board] **Commission** shall, by resolution, allocate funds to individual State colleges, county colleges, and private institutions of higher education within the sector allocations above.

(c) The [Board] **Commission** may reallocate to any institution or to the "emerging needs program" any balance in the amounts authorized if the amounts are not committed within 18 months of the effective date of the Amending Act (June 5, 1993) or within 18 months of subsequent allocations by the [Board] **Commission.** Funds will be considered committed when a lease agreement has been entered into between an institution and the Authority.

(d) No reallocation shall be made pursuant to (c) above if:

1. The request for approval has been received by the [Board] **Commission** within 15 months of June 5, 1993 or within 18 months with respect to any amounts that are reallocated or subsequently allocated by the [Board] **Commission**; or

2.-3. (No change.)

4. Other compelling and documentable reasons exist as determined by the [Board] **Commission.**

(e) An institution's inability to secure the necessary funds to pay the 25 percent principal and interest payments [of] **on** bonds issued to finance equipment [to] **for** such institutions shall not constitute good cause for not committing funds as required in (c) above.

(f) The [Chancellor] **Executive Director** shall contact all institutions to which funds have been allocated 15 months following such allocation to determine what, if any, funds will become available for reallocation at 18 months.

(g) The [Board] **Commission** shall determine the allocation of money available from the authorization of new bonds by the Treasurer as a result of the retirement of bonds previously issued by the Authority pursuant to the Amending Act.

(h) The [Chancellor] **Chair** shall periodically establish and notify institutions of priority areas for the use of funds for emerging needs programs to meet new and advanced technology needs or support new academic programs in science and technology. Institutions may submit an application for funds for a program within the priority areas. The [Chancellor] **Chair** shall review applications on a case by case basis and make recommendations for [Board] **Commission** approval to fund emerging needs programs.

[9:17-1.6]**9A:14-1.6** Reporting requirements

The Authority shall report its equipment purchases to the [Board] **Commission** once in each year in which equipment purchases are made. The [Board] **Commission** then shall report to the Governor and the Legislature on equipment purchases that have been approved by the [Board] **Commission** and financed through this program.

(a)

COMMISSION ON HIGHER EDUCATION

Rules and Procedures for Implementation of the Higher Education Facilities Trust Fund Act

Proposed Recodification with Amendments: N.J.A.C. 9:18 to 9A:15

Authorized By: Commission on Higher Education, Joseph D. Williams, Chair.

Authority: N.J.S.A. 18A:72A-49 and P.L. 1993, c.375.

Proposal Number: PRN 1994-651.

Submit comments by January 18, 1995 to:

Dr. Jeanne Oswald
Administrative Practice Officer
Commission on Higher Education
20 West State Street
CN 542
Trenton, New Jersey 08625

The agency proposal follows:

Summary

On January 10, 1994, P.L. 1993, c.375 was enacted. The law establishes a higher education facilities trust fund in the New Jersey Educational Facilities Authority. The Act authorizes the Authority to issue bonds in a total outstanding principal amount of $220,000,000 to finance the cost, or portion of the cost, of the construction, reconstruction, development, extension, or improvement of instructional, laboratory, communication, and research facilities related to future industry and workforce needs at New Jersey public and private institutions of higher education.

Rules effective June 20, 1994 were promulgated that required the Board of Higher Education to approve all projects financed through the Higher Education Facilities Trust Fund. Technical amendments to N.J.A.C. 9:18 are now proposed to reflect the Higher Education Restructuring Act of 1994, which abolished the Board and Department of Higher Education and the position of Chancellor of Higher Education. A brief summary of the affected sections follows:

N.J.A.C. 9:18-1.2 consists primarily of definitions pertinent to the rules; deleted is the reference to the Chancellor of Higher Education and

added are definitions of the Commission on Higher Education and the Chair and Executive Director of the Commission; also, three typographical errors are corrected. The term "Board" is amended to indicate it refers to the former State Board of Higher Education.

N.J.A.C. 9:18-1.3 delineates the process for applying for grants from the Higher Education Facilities Trust Fund and specifies the information that must be included in applications. One reference to the "Chancellor" is replaced with "Executive Director", and another, with "Commission"; references to the "Board" are replaced with "Commission" or "or Commission", depending on whether the section concerns actions after or before July 1, 1994, the effective date of the Higher Education Restructuring Act.

N.J.A.C. 9:18-1.5 delineates the allocation of the first $220 million among the sectors and specifies how future allocations and reallocations will be determined. The one reference to "Chancellor" is replaced with "Executive Director"; all references to the "Board" are replaced with "Commission."

N.J.A.C. 9:18-1.6 delineates the composition and responsibilities of the Higher Education Facilities Trust Fund Board; "Chancellor" is replaced with "Executive Director", and all references to the "Board" are replaced with "Commission."

In addition, the entire chapter is being recodified from N.J.A.C. 9:18 to 9A:15 to distinguish it from rules that were formerly under the jurisdiction of the Board/Department of Higher Education and in accordance with changes in the statutory responsibilities of the state-level higher education agency.

Social Impact

The Higher Education Restructuring Act of 1994 abolished the Board and Department of Higher Education and the position of Chancellor of Higher Education, while creating a new entity, the New Jersey Commission on Higher Education. The proposed technical amendments are necessary to align regulatory language with the new structure created by the statute.

Economic Impact

The proposed amendments have no discernible economic impact; they are necessitated entirely by statutory changes in the governance/coordinating structure for the New Jersey system of higher education, as delineated in the Higher Education Restructuring Act of 1994.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendments do not impose reporting, recordkeeping, or other compliance requirements on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules apply only to colleges and universities, none of which qualify as a small business as that term is defined by the Act.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]): **(OAL Note:** N.J.A.C. 9:18 is recodified as N.J.A.C. 9A:15)

CHAPTERS 1 THROUGH 13 (RESERVED.)

CHAPTER [18]**15**

RULES AND PROCEDURES FOR IMPLEMENTATION OF THE HIGHER EDUCATION FACILITIES TRUST FUND ACT

[9:18-1.1] **9A:15-1.1** (No change in text.)

[9:18-1.2] **9A:15-1.2** Definitions

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

...

"Board" means **the former** State Board of Higher Education.

...

"Chair" means the Chair of the Commission on Higher Education.

["Chancellor" means the Chancellor of Higher Education.]

"Commission" means the Commission on Higher Education.

"Executive Director" means the Executive Director of the Commission on Higher Education.

...

"South Jersey multi-institutional economic development facilities" means facilities which [whould] **would** promote economic development in the eight southernmost counties of the State, including Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Ocean, and Salem[;], **and** which involve more than one public and/or private institution of higher education.

...

[9:18-1.3] **9A:15-1.3** Process for application for grant

(a) The [Board] **Commission** shall consider for approval grant requests from institutions for the cost, or a portion of the cost, of the construction, reconstruction, development, extension, or improvement of instructional, laboratory, communication, and research facilities. The grants shall be used exclusively for those purposes.

(b) Upon approval by its governing board at a duly authorized meeting, a participating institution shall apply to the [Board] **Commission** for a grant from the trust fund. Proposals shall include the following information:

1.-9. (No change.)

10. Other information as may be required by the [Chancellor] **Executive Director** on a case by case basis and relating to a specific proposal.

(c) The grant request shall be submitted in a format provided by the [Chancellor] **Commission**.

(d) Grant applications must be approved at a public meeting of the [Board] **Commission**.

(e) The total dollar amount of a grant approved for any institution shall not exceed the institution's allocation as approved by the Board **(for allocations made before July 1, 1994) or Commission**.

(f) The [Board] **Commission** shall forward to the Authority a copy of the resolution approved by the [Board] **Commission** including the amount of the grant.

(g) The [Board] **Commission** shall submit to the Legislature a copy of the resolution approving the grant along with the amount of the grant. If the Legislature does not disapprove the grant by the adoption of a concurrent resolution within 60 days, the grant shall be deemed to be authorized.

(h)-(k) (No change.)

[9:18-1.4] **9A:15-1.4** (No change in text.)

[9:18-1.5] **9A:15-1.5** Allocation of funds

(a) (No change.)

(b) The [Board] **Commission** shall, by resolution, allocate funds to individual State colleges, county colleges, and private institutions of higher education within the sector allocations above.

(c) The [Board] **Commission** may reallocate to any institution or to the "South Jersey multi-institutional economic development facilities" any balance in the amounts authorized if the amounts are not approved by the [Board] **Commission** for a grant within 18 months of the effective date of the Amending Act (January 10, 1994) or within 18 months of subsequent allocations by the [Board] **Commission**.

(d) No reallocation shall be made pursuant to (c) above if:

1. The grant application has been received by the [Board] **Commission** within 15 months of January 10, 1994 or within 18 months with respect to any amounts that are subsequently allocated by the [Board] **Commission**; or

2. (No change.)

3. In the sole determination of the [Board] **Commission** there are other compelling and documentable reasons.

(e) The [Chancellor] **Executive Director** shall contact all institutions to which funds have been allocated 15 months following such allocation to determine what, if any, funds will become available for reallocation after 18 months.

(f) The [Board] **Commission** shall determine the allocation of money available from the authorization of new bonds by the Treasurer as a result of the retirement of bonds previously issued by the Authority.

[9:18-1.6] **9A:15-1.6** Higher Education Facilities Trust Fund Board

(a) The Higher Education Facilities Trust Fund Board shall consist of six members, as follows:

1. The Chair and Vice Chair of the [Board] **Commission**;

2.-4. (No change.)

5. The [Chancellor] **Executive Director** who shall serve ex officio without vote.

(b) The Higher Education Facilities Trust Fund Board shall ensure that the revenue provided to the trust fund is adequate to support the grants approved by the [Board] **Commission**.

(c) At the end of each three-year period following the effective date of the Amending Act (January 10, 1994), the Higher Education Facilities Trust Fund Board shall review, in consultation with the [Board] **Commission**, the physical plant needs of public and private institutions in the State and shall recommend to the Governor and Legislature a plan to increase, if necessary, the availability and uses of grants made from the trust fund.

CORRECTIONS

(a)

THE COMMISSIONER

Inmate Liaison Committee

Proposed New Rules: N.J.A.C. 10A:12-2

Authorized By: William H. Fauver, Commissioner, Department of Corrections.

Authority: N.J.S.A. 30:1B-6 and 30:1B-10.

Proposal Number: PRN 1994-635.

Submit comments by January 18, 1995 to:
William H. Fauver, Commissioner
Department of Corrections
CN 863
Trenton, New Jersey 08625

The agency proposal follows:

Summary

It has been the practice within the New Jersey Department of Corrections to permit the organization of an authorized inmate group to act as liaison between the correctional facility administration and the inmate population. These new rules provide guidelines for the composition of the committee, the development of the committee constitution and bylaws, and the physical facilities and equipment that may be provided. These new rules also allow the correctional facility administration to authorize an alternative to the Inmate Liaison Committee and establish that written procedures governing this alternate plan be approved by the Chief of Staff, New Jersey Department of Corrections.

Social Impact

The proposed new rules, which permit the organization of an Inmate Liaison Committee, provide a systematic arrangement by which the inmate population and the correctional facility administration may use to communicate. Through the committee, inmates may voice their comments or arguments concerning issues and problem matters, and the correctional facility may provide information and responses to issues and problematic matters. The Department of Corrections does not anticipate adverse reaction to the proposed new rules.

Economic Impact

Additional funding will not be needed to implement or maintain these new rules. These rules could have a possible economic impact by providing a means of enabling inmates to voice issues of concern which could help to deter destructive behavior in the correctional setting.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed new rules do not impose reporting, recordkeeping or other compliance requirements on small businesses, as defined under the Regulatory Flexibility Act, N.J.A.C. 52:14B-16 et seq. The proposed new rules impact on inmates and the New Jersey Department of Corrections and have no effect on small businesses.

Full text of the proposed new rules follows:

CHAPTER 12
INMATE GROUPS

SUBCHAPTER 1. (RESERVED)

SUBCHAPTER 2. INMATE LIAISON COMMITTEE

10A:12-2.1 Definition

The following term, when used in this subchapter, shall have the following meaning unless the context clearly indicates otherwise.

"Inmate Liaison Committee" means a group of inmate representatives, authorized by the correctional facility administration to act on behalf of correctional facility inmates. An authorized inmate group may be known as something other than an Inmate Liaison Committee.

10A:12-2.2 Function of the Inmate Liaison Committee

(a) An Inmate Liaison Committee may be established within each correctional facility or subunit within the main correctional facility in order to:

1. Act as a liaison between the correctional facility administration and the inmate population;
2. Provide the opportunity for interested inmates, through their representatives, to voice their comments, or arguments concerning issues and problem matters; and
3. Provide the opportunity for inmates, through their representatives, to submit information and recommendations on issues and problem matters that affect them.

(b) The correctional facility administration may utilize the Inmate Liaison Committee meetings to provide:

1. Information to the committee and the inmate population; and
2. Responses to previous issues or problematic matters that were brought to the attention of the administration.

10A:12-2.3 Composition of the Inmate Liaison Committee

(a) An Inmate Liaison Committee shall be composed of:

1. Inmates who represent one or more housing units; and
2. Inmates who act as alternates to the inmates who represent one or more housing units.

(b) Representatives and alternate representatives on the Inmate Liaison Committee shall be voted into office by housing unit residents, through secret ballot, for the term established by the Committee's bylaws from the Committee's constitution (see N.J.A.C. 10A:12-2.4).

(c) Vacancies on the Inmate Liaison Committee occur when an inmate:

1. Resigns;
2. Moves to another housing unit;
3. Is voted out of office;
4. Is released from the correctional facility; or
5. Is removed at the discretion of the Superintendent, provided there are grounds for removal from office, which include, but are not limited to, being found guilty of a serious disciplinary charge.

10A:12-2.4 Constitution and bylaws of the Inmate Liaison Committee

(a) Each Inmate Liaison Committee shall develop a constitution and bylaws which shall state the policies and procedures that govern the Committee's operations and shall be established in accordance with the provisions and requirements of this chapter.

(b) The constitution and bylaws shall include, but are not limited to:

1. The inmate titles and their respective duties;
2. The duties of the Committee members;
3. The procedures for the election of inmate and alternative members of the Committee; and
4. The standing committees and their respective functions.

(c) A draft of the constitution and bylaws and any updates shall be submitted to the Superintendent for his or her review and written approval.

(d) Upon written approval by the Superintendent, the Inmate Liaison Committee may commence operation in accordance with the provisions of the approved constitution and bylaws.

10A:12-2.5 Meetings with the Inmate Liaison Committee

(a) The correctional facility Superintendent or his or her designee shall meet with the Inmate Liaison Committee not less than once a month, and other staff members shall be available to meet with the Committee when it is appropriate or necessary.

(b) The minutes of Inmate Liaison Committee Meetings shall be recorded and reviewed for accuracy by the correctional facility staff member who attended the meeting. Copies of the minutes shall be made available to the inmate population and the administration of the correctional facility.

10A:12-2.6 Physical facilities and equipment

(a) Dependent upon available resources and consistent with internal discipline, order, safety and security, the correctional facility may provide office space to the Inmate Liaison Committee for conducting ongoing business.

(b) Access to the office space may be scheduled at the discretion of the Superintendent or his or her designee.

10A:12-2.7 Designation of an alternative to the Inmate Liaison Committee

The Superintendent shall have the authority to designate an alternate to the Inmate Liaison Committee. In instances where a means of providing an alternate liaison between the correctional facility administration and the inmate population has been established, the Superintendent shall submit written procedures governing the existing alternate plan to the Office of the Chief of Staff for his or her written approval.

INSURANCE

(a)

DIVISION OF INSURANCE FRAUD PREVENTION

Health Fraud Prevention/Detection Plans

Proposed New Rules: N.J.A.C. 11:16-5

Authorized By: Andrew J. Karpinski, Commissioner, Department of Insurance.

Authority: N.J.S.A. 17:33A-15 and 17:1C-6(e).

Proposal Number: PRN 1994-663.

Submit comments by January 18, 1995 to:

Donald Bryan, Acting Assistant Commissioner
Department of Insurance
Legislative and Regulatory Affairs
20 West State Street
CN 325
Trenton, NJ 08625

The agency proposal follows:

Summary

The New Jersey Department of Insurance ("Department") proposes new rules in accordance with the New Jersey Insurance Fraud Prevention Act (the "Act") (N.J.S.A. 17:33A-15). The Act, effective January 4, 1994, requires every insurer writing health insurance in this State to file for approval with the Commissioner of the Department of Insurance ("Commissioner") a plan for the prevention of fraudulent health insurance claims ("health fraud prevention/detection plan" or "plan").

The Act specifically requires each insurer to file its plan with the Department within 120 days of the Department's adoption of regulations pursuant to the Act. An insurer's plan or any amendments to a plan shall be deemed approved by the Commissioner if not affirmatively approved or disapproved within 90 days. The Act further requires the Department's Division of Insurance Fraud Prevention ("IFD") to monitor the implementation of approved insurer plans, and to notify the Attorney General of any evidence of criminal activity encountered in the course of such monitoring. Each insurer subject to the Act shall annually report to IFD on its experience in implementing its health fraud detection plan.

In addition to the requirements imposed by the Act upon insurers and the IFD, the Act permits the Commissioner to impose penalties on an insurer in an amount not to exceed $5,000 per day for failure to comply with the requirements of the Act. Any penalties collected pursuant to the Act are to be deposited in the unemployment compensation fund created pursuant to N.J.S.A. 43:21-9 for use as specified therein.

The Department believes that insurers can significantly reduce the cost of health insurance by undertaking a conscientious effort to reduce fraud through the implementation of health fraud prevention/detection plans. These proposed new rules establish standards for the Commissioner's approval of an insurer's proposed plan. The rules additionally set forth filing and approval procedures for the plans, as well as insurer reporting and recordkeeping requirements.

Prior to proposal of these rules, the Department sought insurer input concerning the proposed rules both by way of a Bulletin inviting written suggestions and by meeting with several insurers required to comply with the rules' requirements. Accordingly, the rules as proposed reflect to the extent possible the comments and suggestions provided by the insurers. Specifically, insurers offering only limited benefits contracts (for example, medicare supplement, dental only or vision only) will be required to employ a reduced number of special investigative unit (SIU) investigators than insurers offering comprehensive benefits. Moreover, all insurers covering less than 10,000 lives will be exempt from the requirements to establish a full-time SIU, to provide fraud education for claims personnel, or to design and disseminate a fraud detection procedures manual.

N.J.A.C. 11:16-5.1 states the purpose and scope of the rules.

N.J.A.C. 11:16-5.2 provides definitions for terms used in the rules.

N.J.A.C. 11:16-5.3 sets forth general insurer filing requirements.

N.J.A.C. 11:16-5.4 contains the standards for approval of an insurer's health fraud prevention/detection plan.

N.J.A.C. 11:16-5.5 sets forth the procedures an insurer is required to follow to obtain approval for a health fraud prevention/detection plan.

N.J.A.C. 11:16-5.6 sets forth the records an insurer is required to maintain and the annual reports an insurer is required to file with the Commissioner concerning its health fraud prevention/detection plan.

N.J.A.C. 11:16-5.7 states that an insurer shall be subject to penalties for non-compliance with the requirements of these proposed rules.

Social Impact

The proposed new rules will have a positive social impact insofar as the implementation of fraud detection plans by health insurers can significantly reduce the cost of health insurance to consumers.

Economic Impact

The proposed new rules are expected to reduce the cost of health insurance by requiring health insurers to implement fraud prevention/detection plans.

The Department acknowledges that health insurers will incur certain costs related to implementing these plans pursuant to N.J.S.A. 17:33A-15. However, the Department believes that the costs associated with implementing such plans will be more than offset by a reduction in fraudulent health insurance applications and claims. The costs of establishing fraud prevention/detection plans may vary among health insurers depending upon the resources currently expended by an individual insurer for the purpose of detecting fraud.

The Department will incur additional costs associated with the initial review and approval of insurer health fraud detection plans, and the monitoring of the plans implemented by insurers.

Regulatory Flexibility Analysis

The proposed new rules impose reporting, recordkeeping and compliance requirements on all insurers writing health insurance in this State, some of which may be "small businesses" as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules' requirements, however, are somewhat relaxed insofar as they pertain to small business insurers in order to minimize any adverse economic impact on such insurers.

These rules will generally require all insurers writing health insurance in this State to file with the Department a health fraud prevention/detection plan for approval by the Commissioner, and to implement an approved plan. Insurers are additionally required to establish a full-time Special Investigations Unit for the purpose of conducting investigations on claims suspected of being fraudulent. Insurers are also required annually to submit to the Department records related to their ongoing implementation of fraud prevention/detection plans, as well as certain reports and data regarding possibly fraudulent claims.

However, the rules' compliance requirements have been relaxed for small business insurers. Insurers insuring less than 10,000 lives are not

required to establish a full-time special investigation unit, to provide fraud education for claims personnel, or to design and disseminate a fraud detection procedures manual. Moreover, insurers offering limited benefits contracts, such as dental only or vision only, are required to employ a reduced number of SIU investigators than insurers offering comperehensive benefits contracts.

Full text of the proposed new rules follows:

SUBCHAPTER 5. HEALTH FRAUD PREVENTION/ DETECTION PLANS

11:16-5.1 Purpose and scope

(a) The purpose of this subchapter is to set forth standards and approval procedures whereby insurers shall file health fraud prevention/detection plans with the Commissioner pursuant to N.J.S.A. 17:33A-15.

(b) This subchapter shall apply to all insurers as defined at N.J.A.C. 11:16-5.2 transacting the business of health insurance in this State.

11:16-5.2 Definitions

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

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

"Contract" means any plan, policy or other agareement entered into or issued by an insurer for health insurance benefits.

"Department" means the New Jersey Department of Insurance.

"Health fraud prevention detection plan" or "plan" means the health insurer's plan for the prevention and detection of fraudulent insurance applications and claims.

"IFD" means the New Jersey Division of Insurance Fraud Prevention established by N.J.S.A. 17:33A-8.

"Insured lives" means the actual number of persons entitled to receive benefits under a contract entered into or issued by an insurer.

"Insurer" means any person or entity authorized to transact the business of health insurance in this State as defined in subsections a, b, c, d, e and f of N.J.S.A. 17:33A-3, including insurance companies operating pursuant to N.J.S.A. 17:17-1 et seq. and 17B:17-1 et seq.; medical service corporations operating pursuant to N.J.S.A. 17:48A-1 et seq.; hospital service corporations operating pursuant to N.J.S.A. 17:48-1 et seq., health service corporations operating pursuant to N.J.S.A. 17:48E-1 et seq.; dental service corporations operating pursuant to N.J.S.A. 17:48C-1 et seq., and dental plan organizations operating pursuant to N.J.S.A. 17:48D-1 et seq.

"Special investigation unit" or "SIU" means the functional group established by an insurer to carry out the duties set forth in this subchapter.

11:16-5.3 General requirements

All insurers transacting the business of health insurance in this State shall file for approval with the Commissioner a health fraud prevention/detection plan pursuant to N.J.S.A. 17:33A-15 and this subchapter. No insurer shall use or implement any plan not filed and approved as set forth in this subchapter.

11:16-5.4 Standards for approval of health fraud prevention/ detection plans

(a) For purposes of obtaining the Commissioner's approval, an insurer's health fraud prevention/detection plan filed with the Department pursuant to this subchapter shall meet the criteria set forth in this section.

(b) Except for insurers which insure less than 10,000 lives, the plan shall establish a full-time special investigations unit (SIU).

1. The SIU shall be a separate unit from the insurer's claims adjusting function.

2. Insurers shall employ the following number of SIU investigators:

i. Insurers offering comprehensive benefits contracts shall employ at least one SIU investigator for every 60,000 insured lives.

ii. Insurers offering limited benefits contracts shall employ at least one SIU investigator for every 250,000 insured lives. Limited benefits contracts shall include, but not be limited to, the following: accident only; credit; disability; long-term care; medicare supplement; dental only; vision only; insurance issued as a supplement to liability insurance; and any supplemental hospital indemnity benefits.

3. An SIU investigator shall be qualified by education and/or experience, which shall include either a bachelor's degree and one to three years of insurance claims investigation experience or five years of law enforcement investigation experience involving economic crimes.

4. The SIU shall conduct investigations on claims referred by the insurer's claim personnel whenever fraud is suspected.

5. In addition to actually performing investigations, the duties of an SIU investigator shall include, but not be limited to, the following:

i. Providing liaison with the IFD and law enforcement personnel;

ii. Providing in-service training to claims personnel;

iii. Maintaining a data base on fraudulent claims;

iv. Identifying persons and organizations that are involved in suspicious claim activity; and

v. Initiating civil or criminal actions based on their investigations as authorized by the insurer.

(c) Except for insurers which insure less than 10,000 lives, the plan shall provide health fraud education for claims personnel which shall contain a detailed and comprehensive program of health insurance fraud awareness and education to prepare claims personnel for health fraud detection.

1. The program shall consist of formal, specialized training for adjusters, claims processors and investigators.

2. Training shall be provided in the following specialties: overcharging and overpayment detection; claims processing guidelines; medical coding; duplicate bills; excessive charges; unnecessary services or supplies; overutilization; services never rendered; miscoded or misleading claim information; hospital inpatient or outpatient billing abuse or inappropriate commitment or confinement; abusive or fraudulent referrals; instruction on technology to detect health claim fraud; statutory requirements dealing with fraud referrals.

(d) Except for insurers which insure less than 10,000 lives, the plan shall provide a Health Fraud Detection Procedures Manual and disseminate it to all claims personnel for the handling of suspicious health insurance claims. The Health Fraud Detection Procedures Manual shall include the following:

1. Information for claims personnel and SIU investigators regarding general investigation guidelines; unfair claims practices; conducting interviews; report writing; information disclosure; law enforcement relations; and the New Jersey Insurance Fraud Prevention Act;

2. The process to be employed when a suspicious claim is identified;

3. The "fraud profiles" or indicators for health fraud;

4. The duties and functions of the SIU;

5. The procedure for referral of a claim to the SIU; and

6. The post-referral procedure for communication between the claims unit and the SIU.

(e) The plan shall provide that all suspicious claims be referred to the IFD as soon as practical on the prescribed reporting form (as set forth in N.J.A.C. 11:16-4 Appendix A), and that the SIU thereafter cooperate with the IFD investigation. The IFD will assist insurers by providing necessary information, such as fraud profiles or indicators.

(f) The insurer shall permit the IFD access to its offices upon reasonable notice and at reasonable hours to conduct on site review of the insurer's compliance with its fraud prevention/detection health plan.

(g) The plan may include such other items the insurer determines to be reasonable and appropriate.

11:16-5.5 Filing and approval procedures for health fraud prevention/detection plans

(a) For purposes of utilizing or implementing a health fraud detection/prevention plan, insurers shall submit their plan for approval by the Commissioner to the following address:

Health Anti-Fraud Plans
New Jersey Department of Insurance
Division of Insurance Fraud Prevention
CN 324
Trenton, NJ 08625-0324

1. Insurers currently transacting the business of health insurance in this State shall file their plan with the Commissioner no later than (120 days after the effective date of these rules).

2. Insurers transacting the business of health insurance in this State subsequent to the effective date of this subchapter shall file their plan with the Commissioner no later than 120 days after the date the insurer commences business in this State.

(b) Insurers shall submit a proposed plan on 8½ by 11 inch paper using one side of the page. The first page shall include the insurer's company name, identifying number for this filing, National Association of Insurance Commissioners (NAIC) company number(s), and NAIC group number.

(c) An insurer's proposed plan submitted pursuant to this section shall be deemed approved by the Commissioner if not affirmatively approved or disapproved within 90 days of the date of filing with the Department.

(d) During the 90-day approval period, the Commissioner may request in writing from the insurer such amendments to the proposed plan as are deemed necessary.

(e) Any amendments to a plan submitted by an insurer to the Commissioner pursuant to (d) above shall be deemed approved by the Commissioner if not affirmatively approved or disapproved within 90 days of the date of filing with the Department.

11:16-5.6 Record retention and reporting

(a) Insurers shall maintain up-to-date and accurate records of their health fraud prevention/detection plan which shall at a minimum include the information necessary to complete the annual plan report described in (b) below.

(b) Insurers shall annually file a plan report for the prior calendar year with the Commissioner on or before April 1 of each year, beginning 1996 for the calendar year 1995. The report shall include the following:

1. The number of claims for the preceding calendar year;
2. The number of suspected fraudulent claims referred to the SIU;
3. The number of claims denied for fraud (based on an SIU investigation);
4. The dollar amount of the claims denied for fraud (based on an SIU investigation);
5. The dollar amount expended in implementing a health fraud prevention detection plan; and
6. The dollar amount of restitution obtained as the result of successful fraud investigations.

(c) The report described in (b) above shall be submitted by the insurer to the Commissioner at the following address:

New Jersey Department of Insurance
Division of Fraud Prevention
CN 324
Trenton, NJ 08625-0324

11:16-5.7 Penalties

Failure to comply with the provisions of this subchapter shall subject the insurer to penalties as provided by N.J.S.A. 17:33A-15.

(a)

NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Proposed Amendments: N.J.A.C. 11:20-4.1, 12.3 and 12.5

Reproposed Amendments: N.J.A.C. 11:20 Appendix Exhibits A to G

Proposed New Rule: N.J.A.C. 11:20 Appendix Exhibit Q

Proposed Repeal and New Rule: N.J.A.C. 11:20-3.2

Authorized By: New Jersey Individual Health Coverage Program Board, Charles Wowkanech, Chair.
Authority: N.J.S.A. 17B:27A-2 et seq.
Proposal Number: PRN 1994-646.

Interested persons may testify with respect to proposed changes to the policy forms, Exhibits A through F, at **a public hearing** to be held on Tuesday, December 13, 1994 at 9:30 A.M. at the New Jersey Department of Insurance, 2nd Floor, 20 West State Street, Trenton, New Jersey.

Submit written comments by December 6, 1994 at the following address:

By mail/messenger: Kevin O'Leary, Executive Director
New Jersey Individual Health Coverage Program Board
20 West State Street, 10th Floor
CN 325
Trenton, New Jersey 08625
By fax: (609) 633-3601

The agency proposal follows:

Summary

These proposed amendments, reproposed amendments, and new rules are being promulgated in accordance with N.J.S.A. 17B:27A-16.1 which provides a special procedure whereby the Individual Health Coverage Program ("IHC") Board may adopt certain actions. Pursuant to this procedure, the Board is required to publish notice of its intended action in three newspapers of general circulation, which notice shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views regarding the intended action. Notice of the intended action also is required to be sent to affected trade and professional associations, carriers, and other interested persons who may request such notice.

Concurrently, the Board is required to forward notice of the intended action to the Office of Administrative Law ("OAL") for publication in the New Jersey Register. The Board must provide a minimum 20-day period for all interested persons to submit their written comments on the intended action to the Board. The Board may adopt its intended action immediately upon the close of the specified comment period by submitting the adopted action to the OAL. If the Board elects to adopt the action immediately upon the close of the comment period, it shall respond to the comments timely submitted within a reasonable period of time thereafter. The Board shall prepare a report for public distribution, and publication by the OAL in the New Jersey Register. The report shall include the list of commenters, their relevant comments, and the Board's responses.

The Board proposes a repeal and new rule at N.J.A.C. 11:20-3.2 in order to discontinue the permitted use of alternative policy forms. The proposed new rule requires all carriers to use the standard health benefit plans policy forms and to submit a Certification of Compliance, which will appear as Exhibit Q in the Appendix of N.J.A.C. 11:20. These changes are necessary to provide carriers with guidance concerning the use of the standard policy forms. Moreover, as N.J.A.C. 11:20-3.2(b) made clear, the use of alternative policy forms was intended as a transitional measure to permit carriers some flexibility in coming into conformance with the requirements of the IHC Program. Since the IHC Program has been established and operating for over a year, the need for alternative policy forms is no longer compelling. The use of standard policy forms by all carriers is a key element of the reform of the individual health care market and will be required from January 1, 1995 forward.

The Board proposes amendments to N.J.A.C. 11:20-4.1 to update the address of the Board's administrative office and to require carriers

wishing to use an alternative application form to submit the alternative application form with the Certification of Compliance, proposed as Exhibit Q in this rule proposal.

The Board proposes amending N.J.A.C. 11:20-12.3 and 12.5 to prohibit a carrier from issuing a standard health benefits plan to a person whose coverage by another individual health benefits plan has not terminated or will not terminate within 30 days after the effective date of the standard health benefits plan. The amendment permits a carrier to seek evidence of the termination required by this provision. Further, the amendment provides that a standard health benefits plan issued to a person who does not terminate a prior individual health benefits plan within 30 days of the effective date of the standard plan will have no force and effect. The proposed amendment will eliminate the need for a coordination of benefits among carriers for persons covered by more than one individual health benefits plan. In addition, the amendment addresses the unnecessary and costly duplication of benefits which results from one person's coverage under multiple health benefits plans. Further, the amendment will reduce the possibility of fraud on the part of a policyholder who submits claims to more than one carrier for the same procedure without notifying the carriers that more than one policy is in force, in an attempt to fraudulently collect multiple benefits.

The reduced administrative costs and paymetns for fraudulent claims should result in lower premiums to the policyholder. The amendment should also reduce costs to policyholders who unwittingly pay for duplicative benefits under multiple health benefits plans. The Board believes this amendment is consistent with its statutory authority to set forth reasonable guidelines for the purchase of standard health benefits plans by persons already covered by other individual health benefits plans. N.J.S.A. 17B:27A-11(h). The amendment is also consistent with other requirements in the Individual Health Insurance Reform Act ("IHC Act"), N.J.S.A. 17B:27A-2 et seq., that prohibit duplicative coverage under group and individual health benefits plans.

The Board also reproposes amendments to the: Eligibility; Benefit Deductibles and Coinsurance; Utilization Review; Coordination of Benefits; and the General Provisions sections of the standard policy forms, found in the Appendix to N.J.A.C. 11:20, Exhibits A through F. Proposed amendments to the standard policy forms were originally published at 26 N.J.R. 3356(b). While the Board has adopted most of the changes found in that proposal elsewhere in this issue of the New Jersey Register, it reproposes certain parts of the above-noted sections in this proposal.

The proposed amendments to the: Eligibility; Benefit Deductibles and Coinsurance; and General Provisions sections of the standard policy forms A through E and HMO are made in order to conform the policy forms with the proposed changes to N.J.A.C. 11:21-12.3 and 12.5 which require an individual who has enrolled in a standard health benefits plan to terminate coverage by a prior individual health benefits plan within 30 days after the effective date of a standard health benefits plan.

Also reproposed are changes to the Utilization Review section of the standard policy forms A through E. The standard HMO policy form does not have a utilization review provision. Most of the proposed changes are intended to make the utilization review procedure easier to follow for the policyholder and involve rearranging the language of the existing provision. The key substantive change requires pre-approval for maternity care.

The Board proposes removing the Coordination of Benefits section found in standard policy forms A through E and HMO, Exhibits A through F of the Appendix. The Coordination of Benefits section of the policies is no longer necessary since the Eligibility provision, as amended by this proposal, would prohibit persons who hold individual health benefits plans from obtaining duplicative standard health benefits plans. The elimination of the need for multiple carriers to coordinate benefits and possibly, to return premium to the policyholder, will reduce administrative costs as well as fraudulent claims.

The proposed amendment to the General Provisions section of standard policy forms A through E and HMO adds to the enumerated grounds for a carrier's non-renewal of a standard health benefits plan a section with regard to coverage by other individual health benefits plan. This ensures that carriers have the means to enforce the prohibition on duplicative coverage at the time of both application and renewal.

The Board proposes changes to the Application for Individual Health Benefits Plan, Exhibit G, to implement changes in other rules and Federal and State laws, to collect additional information, and to make the application clearer to the applicant.

The proposal includes a new Certification of Compliance form as Exhibit Q to the Appendix to N.J.A.C. 11:20. The form shall be submitted by carriers in lieu of submitting standard or alternative policy forms. The form collects information about whether a carrier is using an alternative application form, whether the standard plans are being offered as indemnity or managed care products, and what copayment options are being offered under the HMO plan. Carriers will no longer be required to submit standard policy or standard application forms to the Board, but must submit a certification that the standard forms are being used.

Social Impact

The proposed and reproposed amendments and new rules will affect carriers offering individual health benefits plans. All carriers will be required to use standard policy forms, to submit the new certification form, and to adhere to the requirement that they decline to offer coverage by a standard health benefits plan to an individual enrolled in an individual health benefits plan who has not terminated, or will not terminate such coverage within 30 days after the effective date of the standard plan. This requirement will affect individuals who are already covered by an individual health benefits plan and seek to enroll in standard health benefits plans. Those individuals will be issued coverage on the condition that they cancel the prior individual plan within 30 days of the effective date of the standard health benefits plan. To the extent that such individuals decide to cancel the prior individual health benefits plan, carriers that have issued individual health benefits plans to New Jersey residents at some time in the past will be affected by termination of those plans.

Economic Impact

The proposed and reproposed amendments and new rules will have an economic impact primarily on carriers that offer individual health benefits plans. Those carriers will have to revise standard policy forms and adjust systems of administration to conform with such revisions. At the same time, the elimination of duplicative individual coverage will reduce administrative costs to carriers, as well as the costs of fraudulent duplicative payments of benefits to the same person. Individuals will be impacted because they will not be permitted to pay premiums for coverage by more than one individual health benefits plan.

Regulatory Flexibility Analysis

The IHC Board believes that all carriers subject to these rules have in excess of 100 employees or are located outside of the State of New Jersey. Therefore, a regulatory flexibility analysis is not required. However, to the extent that any carrier might be considered a small business under the terms of N.J.S.A. 52:14B-16 et seq., the Regulatory Flexibility Act, the following analysis would apply.

The proposed amendments and new rules to the policy forms and rules to prohibit duplicative coverage and eliminate the need to coordinate benefits among carriers should reduce administrative burdens on carriers subject to these rules. The new certification form creates a new filing, but relieves carriers of the burden of filing standard or alternative policy forms, which filings are considerably larger and more costly. The Board has tried to consolidate as much information into a single certification as possible, rather than require multiple certifications. Since the IHC Program provides a file and use system for policy forms, a certification is a minimal filing requirement. The changes to the application form require carriers to collect more information, but the Board has included more information, in some cases, at the request of carriers who are members of the IHC Program. The information collected in the application form is not sent to the Board.

Full text of proposal follows (additions indicated in boldface **thus**; deletions indicated in cursive brackets {thus}):

11:20-3.2 Policy forms

{(a) For standard health benefits plans policies effective on or after August 1, 1993, members shall use the standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F, except as provided in (b) below. Before marketing the standard policy forms, a member shall file in triplicate with the Board a certification signed by the Chief Executive Officer of the member that sets forth that the standard policy forms will be used by the member.

(b) As a transitional measure, a member may submit to the Board alternative policy forms for the standard health benefits plans, so long as the alternative policy forms are in substantial compliance with the standard policy forms set forth in the Appendix. These alternative policy forms may be used, except as provided in (b)3

and 4 below, until the next anniversary date at which time the member shall issue a standard policy form in accordance with (a) above.

1. The alternative policy form shall be submitted with a certification of the Chief Executive Officer of the member that the policy form submitted for approval is in substantial compliance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20.

2. Alternative individual health benefits plan policy forms shall be submitted in triplicate to the Board at the following address:

Interim Administrator
Individual Health Coverage Program Board
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, New Jersey 08830

3. Upon filing, a member may use an alternative policy form unless and until it has been disapproved in accordance with this rule.

4. After notice and a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, the Board shall disapprove any proposed alternative policy form that:

i. Is not in substantial compliance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20-3;

ii. Is not in substantial compliance with the corresponding standard policy form set forth in the Appendix to this subchapter; and

iii. Does not provide benefit levels that are identical to the benefit levels set forth in the corresponding plan as provided in N.J.A.C. 11:20-3.1.

5. When submitting alternative policy forms, carriers shall submit, along with the certification of substantial compliance, a description of the differences between the alternative policy form(s) and the standard policy form(s) set forth in Exhibits A through F in the Appendix of this chapter, as appropriate.

6. In determining substantial compliance of the alternative policy form with the specific standard policy form, the carrier shall consider in its certification, and the Board shall consider in its review of the alternative policy form and certification whether:

i. The inclusion of words, terms and descriptions not contained in the standard policy forms changes the meaning or effect of any material aspect of the standard health benefits plans or standard application form;

ii. The alternative policy form contains all provisions required by New Jersey law and the standard policy form which, if not the same as that required by law or in the standard policy form, is at least as favorable to the insured or policyholder;

iii. The alternative policy form contains all coverages, coverage limits, and exclusions set forth in the standard policy form;

iv. There is any deviation from the effective date of coverage, renewal or termination provisions in the standard policy forms; and

v. Easy comparison with the appropriate standard policy form by both the consumer and the Board is impeded.

(c) Notwithstanding the provisions of (a) and (b) above, a member choosing to offer a standard health benefits plan through or in conjunction with a managed care network in accordance with N.J.A.C. 11:20-3.1(d) shall submit alternative policy forms which are consistent with N.J.A.C. 11:20-3.1(d) and the purposes of the Act. Upon filing, a member may use such alternative policy form unless and until it has been disapproved in accordance with this rule. Such forms shall be submitted in accordance with (b)2 above. The alternative policy form shall be submitted with a certification of the Chief Executive Officer of the member that the policy form submitted is in substantial compliance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20. After notice and a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, the Board shall disapprove any such proposed alternative policy form that:

1. Is not in substantial compliance with N.J.S.A. 17B:27A-2 et seq., and this subchapter; or

2. Does not provide benefit levels that are identical to the benefit levels set forth in the corresponding plan as provided in N.J.A.C. 11:20-3.1, or has not received approval from the Board for health benefits plans described in N.J.A.C. 11:20-3.1(d)4.}

(a) For standard health benefit plan contracts effective on or after January 1, 1995, members shall use the standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F.

(b) For standard health benefit plan policies with effective dates prior to January 1, 1995, members shall convert the contracts to the respective standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F on the first 12 month contract anniversary date on or after January 1, 1995.

(c) A member choosing to offer a standard health benefits plan through or in conjunction with a managed care network in accordance with N.J.A.C. 11:20-3.1(d) shall use the appropriate standard language set forth in the Appendix to this subchapter as Exhibit Q in conjunction with the standard policy forms set forth as Exhibits A through E.

(d) Before marketing any of the standard policy forms, a member shall file in triplicate with the Board, the Certification Form set forth in the Appendix to this subchapter as Exhibit Q. Affiliated Carriers must file separate Certification Forms. A new Certification Form must be filed any time a member makes any permitted changes in the standard health benefits forms being offered.

11:20-4.1 Standard application form

(a) All members offering standard health benefits plans with an effective date on or after August 1, 1993, shall use the standard application form approved by the Board and specified in Exhibit G of the Appendix to this chapter, except as provided in (b) below.

(b) A member may submit to the Board for approval an alternative application form that differs in format but not in content from the standard form set forth in Exhibit G of the Appendix. The member may use the alternative form when submitted unless and until disapproved by the Board.

{1. The alternative application form shall be submitted with a certification by the Chief Executive Officer of the member that the alternative application form requests only the information specified in the form in Exhibit G of the Appendix.

2. Alternative application forms shall be submitted in triplicate to the Board at the following address:

Interim Administrator
Individual Health Coverage Program Board
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, New Jersey 08830}

11:20-12.3 Eligibility for coverage under a standard health benefits plan

(a) (No change.)

(b) A person shall not be covered by a standard health benefits plan, as the policyholder or a dependent, if the person is eligible for Medicare, Medicaid, {or} a group health benefits plan, except as provided in N.J.A.C. 11:20-12.4, **or if the person is covered by any other individual health benefits plan, except as provided in N.J.A.C. 11:20-12.5(a).**

11:20-12.5 Selection of a standard health benefits plan by a person covered by an individual health benefits plan

(a) A person who is covered by an individual health benefits plan {with an effective date prior to August 1, 1993,} **other than one of the standard health benefits plans issued pursuant to this chapter** may choose, at any time, {to be covered by any standard health benefits plan} **to replace that health benefits plan with any standard health benefits plan. A carrier shall not offer a person coverage by a standard health benefits plan unless the person's coverage by the individual health benefits plan being replaced has been terminated or will terminate no later than 30 days after the effective date of the standard health benefits plan. A carrier may require evidence of such termination. If a person fails to terminate a prior individual health benefits plan as required above, the standard health benefits plan shall be of no force and effect.**

(b)-(g) (No change.)

1. The alternative application form shall be submitted along with the Certification Form set forth in the Appendix to this subchapter as Exhibit Q.

2. Alternative application form shall be submitted in triplicate to the Board at the following address:

Executive Director
New Jersey Individual Health Coverage Program
20 West State Street, 10th Floor
CN 325
Trenton, NJ 08625

3.-5. (No change.)

{(c) In determining substantial compliance, the Board and carrier shall consider whether the alternative application form includes all information required by the standard application form, even information which applies are required to complete at their option, but no information relevant to underwriting or rating of the individual not otherwise contained in the standard application form.}

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II. ELIGIBILITY

TYPES OF COVERAGE

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WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey, ***You are not covered under another individual health benefits plan,*** and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse, ***who is not covered under another individual health benefits plan, and*** who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child, ***who is not covered under another individual health benefits plan,*** who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

NOTE: YOU AND/OR YOUR DEPENDENTS ARE ELIGIBLE FOR COVERAGE UNDER THIS POLICY IF THIS POLICY REPLACES ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN UNDER WHICH YOU AND/OR YOUR DEPENDENTS ARE COVERED. WE MAY REQUIRE PROOF THAT THE OTHER COVERAGE HAS BEEN TERMINATED.

...

V. BENEFIT DEDUCTIBLES AND COINSURANCE

...

{**Benefits From Other Plans:** When another plan furnishes benefits which are similar to Ours, We coordinate Our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than are incurred in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.}

...

VIII. UTILIZATION REVIEW

{OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request For Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Hospice Care
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. In some instances, before We authorize the procedures, services

and supplies listed above, We may require a second opinion. See "Step 3" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

STEP 2—Notice Requirements

For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase.

For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

[For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 4 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 4 below.

If the second opinion does not confirm the need for the procedure, We may require You to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 4 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES**. IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 4—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.}

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION, OR IF, AFTER CONSIDERATION OF SUCH A REQUEST, WE DO NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES AS REQUIRED IN THIS SECTION, WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE ASK YOU TO OBTAIN FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, ANY PAYMENT WE MAKE WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

C. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND THE OPINIONS DO NOT CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

Any reduction of benefits under this provision is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1—Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. ***IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.***

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Maternity Care (See STEP 2 (a))
Hospice Care
Infusion Therapy

STEP 2—Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. *IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.*

(a) For *Non-Medical Emergency* hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must *contact Us at least 3 days prior to admission, treatment or purchase* to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for *maternity care,* You or Your Practitioner must contact Us *within the first 12 weeks of medical confirmation* of a pregnancy. We will send You or Your Practitioner Our acknowledgement of the pregnancy within 7 days.

(b) For *Medical Emergency* hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us *within 48 hours or on the next business day (whichever is later),* from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For *Continued Confinement* as an Inpatient beyond the time authorized, You or Your Provider must contact us *at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,* for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, as well as put in writing to You, what specific information is needed to make that Determination.

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may *require* that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION FOR PERFORMANCE OF THE PROCEDURE AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN, OUR PAYMENT WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4—Obtaining a Third Opinion

If you obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF THE SECOND AND THIRD OPINIONS DO NOT CONFIRM THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If you do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to

the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

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{XI. [XIII.] COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.}

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{[XIII.] XIII. [XV.]} *XII. [XIV.]* GENERAL PROVISIONS

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TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. {But} ***However,*** You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;

(b) fraud or misrepresentation by You or Your Dependents;

(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;

(d) You become eligible either for Medicare, Medicaid or to participate in a Group Health Benefits Plan which provides the same or similar coverage;

(e) {non-renewal as authorized by the Board.} ***You became covered under another individual health benefits plan;***

(f) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

EXHIBIT B

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V. BENEFIT DEDUCTIBLES AND COINSURANCE

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{**Benefits From Other Plans:** When another plan furnishes benefits which are similar to Ours, We coordinate Our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than are incurred in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.}

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VIII. UTILIZATION REVIEW

{OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request For Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement

Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Hospice Care
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

STEP 2—Notice Requirements

For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase.

For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

[For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 4 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 4 below.

If the second opinion does not confirm the need for the procedure, We may require You to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 4 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 4—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.]

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B. IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE ASK YOU TO OBTAIN FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, ANY PAYMENT WE MAKE WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

C. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND THE OPINIONS DO NOT CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

Any reduction of benefits under this provision is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1—Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. *IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.*

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Maternity Care (See STEP 2 (a))
Hospice Care
Infusion Therapy

STEP 2—Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. *IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.*

(a) For *Non-Medical Emergency* hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must *contact Us at least 3 days prior to admission, treatment or purchase* to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for *maternity care,* You or Your Practitioner must contact Us *within the first 12 weeks of medical confirmation* of a pregnancy. We will send You or Your Practitioner Our acknowledgement of the pregnancy within 7 days.

(b) For *Medical Emergency* hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us *within 48 hours or on the next business day (whichever is later),* from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For *Continued Confinement* as an Inpatient beyond the time authorized, You or Your Provider must contact us *at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,* for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, as well as put in writing to You, what specific information is needed to make that Determination.

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may *require* that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION FOR PERFORMANCE OF THE PROCEDURE AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN, OUR PAYMENT WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4—Obtaining a Third Opinion

If you obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF THE SECOND AND THIRD OPINIONS DO NOT CONFIRM THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If you do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

. . .

{XI. [XIII.] COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less thanf $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.}

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***XII. [XIV.]* [XV.] GENERAL PROVISIONS**

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TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. {But} ***However,*** You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;

(b) fraud or misrepresentation by You or Your Dependents;

(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;

(d) You become eligible either for Medicare, Medicaid or to participate in a Group Health Benefits Plan which provides the same or similar coverage;

(e) {non-renewal as authorized by the Board.} ***You became covered under another individual health benefits plan;***

(f) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

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II. ELIGIBILITY

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. . .

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey, ***You are not covered under another individual health benefits plan,*** and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse, ***who is not covered under another individual health benefits plan, and*** who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child, ***who is not covered under another individual health benefits plan,*** who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

NOTE: YOU AND/OR YOUR DEPENDENTS ARE ELIGIBLE FOR COVERAGE UNDER THIS POLICY IF THIS POLICY REPLACES ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN UNDER WHICH YOU AND/OR YOUR DEPENDENTS ARE COVERED. WE MAY REQUIRE PROOF THAT THE OTHER COVERAGE HAS BEEN TERMINATED.

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II. ELIGIBILITY

TYPES OF COVERAGE

...

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey, ***You are not covered under another individual health benefits plan,*** and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse, ***who is not covered under another individual health benefits plan, and*** who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child, ***who is not covered under another individual health benefits plan,*** who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

NOTE: YOU AND/OR YOUR DEPENDENTS ARE ELIGIBLE FOR COVERAGE UNDER THIS POLICY IF THIS POLICY REPLACES ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN UNDER WHICH YOU AND/OR YOUR DEPENDENTS ARE COVERED. WE MAY REQUIRE PROOF THAT THE OTHER COVERAGE HAS BEEN TERMINATED.

...

V. BENEFIT DEDUCTIBLES AND COINSURANCE

...

{**Benefits From Other Plans:** When another plan furnishes benefits which are similar to Ours, We coordinate Our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than are incurred in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.}

...

VIII. UTILIZATION REVIEW

{OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request For Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Hospice Care
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

STEP 2—Notice Requirements

For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase.

For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

[For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 4 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 4 below.

If the second opinion does not confirm the need for the procedure, We may require You to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 4 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 4—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.]

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION, OR IF, AFTER CONSIDERATION OF SUCH A REQUEST, WE DO NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES AS REQUIRED IN THIS SECTION, WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE ASK YOU TO OBTAIN FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, ANY PAYMENT WE MAKE WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

C. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND THE OPINIONS DO NOT CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

Any reduction of benefits under this provision is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1—Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitalization, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. ***IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.***

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy

Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Maternity Care (See STEP 2 (a))
Hospice Care
Infusion Therapy

STEP 2—Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. *IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.*

(a) For *Non-Medical Emergency* hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must *contact Us at least 3 days prior to admission, treatment or purchase* to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for *maternity care,* You or Your Practitioner must contact Us *within the first 12 weeks of medical confirmation* of a pregnancy. We will send You or Your Practitioner Our acknowledgement of the pregnancy within 7 days.

(b) For *Medical Emergency* hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us *within 48 hours or on the next business day (whichever is later),* from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For *Continued Confinement* as an Inpatient beyond the time authorized, You or Your Provider must contact us *at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,* for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, as well as put in writing to You, what specific information is needed to make that Determination.

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may *require* that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION FOR PERFORMANCE OF THE PROCEDURE AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN, OUR PAYMENT WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4—Obtaining a Third Opinion

If you obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the third opinion, subject to all Policy limitations and exclusions.

IF THE SECOND AND THIRD OPINIONS DO NOT CONFIRM THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If you do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

. . .

[XI. [XIII.] COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.}

...

XII. [XIV.] [XV.] GENERAL PROVISIONS

...

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. {But} ***However,*** You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;
(d) You become eligible either for Medicare, Medicaid or to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) {non-renewal as authorized by the Board.} ***You became covered under another individual health benefits plan;***
(f) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

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EXHIBIT E

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...

II. ELIGIBILITY

...

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey, ***You are not covered under another individual health benefits plan,*** and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(b) **SPOUSE**—Your Spouse, ***who is not covered under another individual health benefits plan, and*** who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(c) **CHILD**—Your Child, ***who is not covered under another individual health benefits plan,*** who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

NOTE: YOU AND/OR YOUR DEPENDENTS ARE ELIGIBLE FOR COVERAGE UNDER THIS POLICY IF THIS POLICY REPLACES ANOTHER INDIVIDUAL HEALTH BENEFITS PLAN UNDER WHICH YOU AND/OR YOUR DEPENDENTS ARE COVERED. WE MAY REQUIRE PROOF THAT THE OTHER COVERAGE HAS BEEN TERMINATED.

...

V. BENEFIT DEDUCTIBLES AND COINSURANCE

...

{**Benefits From Other Plans:** When another plan furnishes benefits which are similar to Ours, We coordinate Our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than are incurred in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.}

...

VIII. UTILIZATION REVIEW

{OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request For Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation

Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Hospice Care
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

STEP 2—Notice Requirements

For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase.

For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

[For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 4 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 4 below.

If the second opinion does not confirm the need for the procedure, We may require You to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 4 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 4—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.]

THE DECISIONS MADE BY OUR REPRESENTATIVE(S) IN THIS UTILIZATION REVIEW PROGRAM ARE INTENDED ONLY TO DETERMINE THE EXTENT OF REIMBURSEMENT FOR A SERVICE.

OUR PAYMENT WILL BE REDUCED FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION.

A. IF YOU OR YOUR PRACTITIONER DO NOT REQUEST OUR AUTHORIZATION, OR IF, AFTER CONSIDERATION OF SUCH A REQUEST, WE DO NOT AUTHORIZE A HOSPITAL ADMISSION OR PROCEDURE, SERVICES OR SUPPLIES AS REQUIRED IN THIS SECTION, WE WILL REDUCE ANY PAYMENT WE MAKE BY 50% PROVIDED WE DETERMINE THE HOSPITAL ADMISSION, PROCEDURE, SERVICE OR SUPPLIES WERE MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

B. IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE ASK YOU TO OBTAIN FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, ANY PAYMENT WE MAKE WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

C. IF YOU OBTAIN A SECOND AND THIRD OPINION FOR PERFORMANCE OF A SURGICAL PROCEDURE OR HOSPITAL ADMISSION, AND THE OPINIONS DO NOT CONFIRM THE NEED FOR THE PROCEDURE OR HOSPITALIZATION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF ANY REDUCTION OF BENEFITS (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

Any reduction of benefits under this provision is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

STEP 1—Request For Care Preapproval

If Your Practitioner recommends that You (a) be admitted, for any reason, as an Inpatient; or (b) undergo any of the Surgical procedures or receive other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the hospitaliza-

tion, procedures or other services and supplies are Medically Necessary and Appropriate.

Failure to notify Us of the procedures, services or supplies as provided in Step 2 below, will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

In some instances, before We authorize a hospitalization or the performance of a surgical procedure listed, We may require a second and/or third opinion. See "Step 3" and "Step 4" below.

Our authorization is valid for 30 days. If the hospitalization, procedure, service or use of the supply does not occur as planned, You or Your Practitioner must contact Us to renew the authorization. If the authorization is not renewed, We will consider the hospitalization, procedure, service or supply as not authorized.

If You or Your Practitioner obtain Our authorization for one of the listed procedures, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our Payment will not be affected. *IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.*

PROCEDURES, SERVICES AND SUPPLIES REQUIRING PREAPPROVAL

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Maternity Care (See STEP 2 (a))
Hospice Care
Infusion Therapy

STEP 2—Notice Requirements

If We are notified within the required time and We Determine that the procedures, services or supplies are Medically Necessary and Appropriate, Our Payment will not be affected. *IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.*

(a) For *Non-Medical Emergency* hospitalizations, procedures, services or supplies listed above, You or Your Practitioner must *contact Us at least 3 days prior to admission, treatment or purchase* to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within those 3 days. However, for *maternity care,* You or Your Practitioner must contact Us *within the first 12 weeks of medical confirmation* of a pregnancy. We will send You or Your Practitioner Our acknowledgement of the pregnancy within 7 days.

(b) For *Medical Emergency* hospitalizations, procedures, services or supplies You or Your Practitioner must contact Us *within 48 hours or on the next business day (whichever is later),* from the commencement of hospitalization, treatment, or use of supplies, whichever is later, to obtain Our authorization. We will provide You or Your Practitioner with Our Determination within 48 hours.

(c) For *Continued Confinement* as an Inpatient beyond the time authorized, You or Your Provider must contact us *at least 1 full day, i.e. 24 hours, prior to the preapproved discharge date,* for additional authorization. We will provide You or Your Practitioner with Our Determination within those 24 hours.

In the event We are not able to provide You or Your Practitioner with a Determination within the time frames stated, We will tell You and Your Practitioner before the mid-point of the time stated, as well as put in writing to You, what specific information is needed to make that Determination.

In the event We do not authorize the hospitalization, procedure, service or supplies, We will send You a written statement within 7 days, explaining the specific reasons for denial of the authorization. Any such denial of Our authorization is subject to Your rights under the "Claims Appeal" section of the "Claims Procedure" provision of this Policy.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtaining a Second Opinion

You may always obtain a second opinion when You are advised to have Surgery or be hospitalized. We may *require* that You obtain a second opinion if We Determine that it is necessary in order for Us to authorize a surgical procedure or hospital admission. If We Determine that a second opinion is necessary, We may arrange for the second opinion consultation. Regardless of whether the second opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for a surgical procedure, We, in consultation with Your Practitioner, will authorize the appropriate setting (Inpatient or Outpatient) for the proposed procedure. If We approve an Inpatient admission, You or Your Practitioner may proceed with the admission and Our payment will not be affected.

IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION FOR PERFORMANCE OF THE PROCEDURE AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.

IF YOU DO NOT OBTAIN A SECOND OPINION WHICH WE ASK YOU TO OBTAIN, OUR PAYMENT WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE HOSPITALIZATION OR PERFORMANCE OF THE SURGICAL PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE SURGICAL PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second opinion is valid for 90 days. If You do not undergo the surgical procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the hospital admission or the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

If the second opinion does not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You obtain a third opinion.

STEP 4—Obtaining a Third Opinion

If you obtained a second opinion and it did not confirm the need for the surgical procedure or hospital admission, You may obtain or We may require You to obtain a third opinion. Regardless of whether the third opinion is at Our request or Yours, We will pay for the consultation and for any Diagnostic Services and Pre-Admission Testing

necessary for the third opinion, subject to all Policy limitations and exclusions.

IF THE SECOND AND THIRD OPINIONS DO NOT CONFIRM THE NEED FOR THE SURGICAL PROCEDURE OR HOSPITAL ADMISSION AND YOU PROCEED WITH THE PROCEDURE OR HOSPITALIZATION, WE WILL NOT PAY FOR THE PROCEDURE OR HOSPITALIZATION NOR ANY ASSOCIATED PRACTITIONER (INCLUDING FACILITY) CHARGES.

IF YOU DO NOT OBTAIN A THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE OR HOSPITALIZATION WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS MEDICALLY NECESSARY AND APPROPRIATE. IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE OR THE HOSPITALIZATION WAS NOT MEDICALLY NECESSARY AND APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming third opinion is valid for 90 days. If you do not undergo the procedure or become hospitalized within that time, You or Your Practitioner must notify Us and renew the confirming opinion prior to the procedure being performed or the hospitalization. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

. . .

{XI. [XIII.] COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.}

. . .

XII. [XIV.] [XV.] GENERAL PROVISIONS

. . .

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. {But} ***However,*** You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;

(b) fraud or misrepresentation by You or Your Dependents;

(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;

(d) You become eligible either for Medicare, Medicaid or to participate in a Group Health Benefits Plan which provides the same or similar coverage;

(e) {non-renewal as authorized by the Board.} ***You became covered under another individual health benefits plan;***

(f) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

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EXHIBIT F

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II. ELIGIBILITY

TYPES OF COVERAGE

A Contractholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Contract for the Contractholder only.

(b) **FAMILY COVERAGE**—coverage under this Contract for You and Your Dependent(s).

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Contract for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.

(d) **HUSBAND AND WIFE COVERAGE**—coverage under this Contract for You and Your Spouse.

WHO IS ELIGIBLE

(a) **THE CONTRACTHOLDER**—You, if Your Primary Residence is in the designated service area in the State of New Jersey, ***You are not covered under another individual health benefits plan,*** and You are not eligible for a Group Health Benefits Plan that provides the same or similar coverage, Medicare or Medicaid.

(b) **SPOUSE**—Your Spouse, ***who is not covered under another individual health benefits plan, and*** who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides same or similar coverage.

(c) **CHILD**—Your Child, ***who is not covered under another individual health benefits plan,*** who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Contract.

NOTE: YOU AND/OR YOUR DEPENDENTS ARE ELIGIBLE FOR COVERAGE UNDER THIS POLICY IF THIS POLICY REPLACES ANOTHER

INDIVIDUAL HEALTH BENEFITS PLAN UNDER WHICH YOU AND/OR YOUR DEPENDENTS ARE COVERED. WE MAY REQUIRE PROOF THAT THE OTHER COVERAGE HAS BEEN TERMINATED.

...

{VIII. COORDINATION OF BENEFITS

If Covered Services are provided under this Contract and these same Covered Services or expenses are covered under Other Valid Coverage, Our liability will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our liability on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Services) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Services) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the reasonable cash value of the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, health service corporations, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.}

...

{X.} *IX.* GENERAL PROVISIONS

...

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Contract will end when that period ends. {But} ***However,*** You may write to Us, in advance, to ask that the Contract be terminated at the end of any period for which Premiums have been paid. Then the Contract will end on the date requested.

This Contract will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;

(b) fraud or misrepresentation by You or Your Dependents;

(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;

(d) You become eligible either for Medicare, Medicaid or to participate in a Group Health Benefits Plan which provides the same or similar coverage;

(e) {non-renewal as authorized by the Board.} ***You became covered under another individual health benefits plan;***

(f) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

...

EXHIBIT G

APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN FOR INDIVIDUALS AND FAMILIES

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c.161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover must not be eligible to be covered under:
   (a) a group health benefits plan that provides same or similar coverage for hospital and medical expenses;
   (b) Medicare; or
   (c) Medicaid **(Recent changes in federal law may allow you to purchase an individual health benefits plan even if you are eligible for Medicaid. Ask about this when you apply for coverage.)**
4. {Please note that benefits under this plan may be reduced if the benefits are also covered under another individual health benefits plan.} **You and any family members you wish to cover are not eligible for a standard individual health benefits plan if covered by another individual health benefits plan unless the other plan is being replaced by the plan being applied for with this application.**
5. The effective date of your coverage shall be no later than the first of the month following the month in which the completed application was dated {(}and premium payment is received{)}.

INDIVIDUAL APPLICATION INSTRUCTIONS

BEFORE COMPLETING THIS APPLICATION BE SURE TO FAMILIARIZE YOURSELF WITH THE BENEFIT OPTIONS AVAILABLE. [NOTE: [CARRIER'S] PARTICIPATING PROVIDERS, INCLUDING ALL [PARTICIPATING] [NETWORK] PRIMARY CARE PHYSICIANS, ARE INDEPENDENT CONTRACTORS AND ARE NOT AGENTS OR EMPLOYEES OF {CARRIER].]

COMPLETE ALL SECTIONS IF YOU ARE:

1. [Applying] [Enrolling[as a new [insured] [enrolled] [subscriber] **[member]**.
2. Changing dependent coverage.

[COMPLETE SECTIONS 1, 2, 3, **[AND]** [5] AND [6] IF YOU ARE TERMINATING YOUR COVERAGE.

Section 1—Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide date of birth, sex, and social security number for each individual listed. {Note:} Your social security number is for **our** {the} use {of the insurance carrier}; {the}. **The** New Jersey Individual Health Coverage **Program** Board will not collect or use {this information} **your social security number**. If a dependent is a full-time college student, you **must** attach a current course schedule or tuition receipt. If a dependent is beyond age {20} **19** or 23, as applicable, but is mentally or physically handicapped, unmarried and chiefly dependent upon the application or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked **only** if you wish to add or remove a dependent from the plan.

Section 2—Complete all information.

Section 3—Check box(es) indicating options for coverage, type of contract, [payment plan] and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4—This information is required. Please complete all information.

[Section 5—**For applicants only**] From the appropriate **[directory] [brochure]** [ ] choose [the location number for] a Primary Care Physician [or **Health** Center] **[and/or {GYN} Gynecologist** {(}if applicable{)},] **[for yourself and each member of your family]** [{(}required for all members{)}]. **[If you choose a Health Center, you must choose a Primary Care Physician who services that Health Center.] [Indicate whether you are choosing [carrier's] Statewide Physician Network or Health Center.]** Check the change box only if you are changing providers{]}.

Section [5/6]—Applicant **must sign** this section and date this form {for any activity} or it will not be processed.

Section [6/7]—{This information may be supplied voluntarily. Check appropriate box.} **Completion of this section is optional.**

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed **[on the following page,]** [on the reverse side,] I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by (carrier) after a review of the application [and receipt of payment].
2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under {twenty} **nineteen** {(20)} **(19)** years of age, unmarried children who are mentally or physically incapacitated and who are chiefly

dependent upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of {twenty} **nineteen** {(20)} **(19)** and twenty-three (23) who are full-time students at an accredited educational institution {and receive at least half their support from applicant and/or applicant's spouse and neither applicant's spouse nor children are eligible for group health benefits coverage}.

3. Coverage and benefits are contingent on timely payment of premiums {and}. **Coverage** may be terminated as provided in the Individual [Contract] **[Policy]**.
4. The Individual [Contract] **[Policy]** will determine the rights and responsibilities of [insured(s)] [enrollee(s)] [subscriber(s)] **[member(s)]** and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.

[5. As a condition to benefits, applicant understands and agrees that (with the exception of a medical emergency as defined in the Individual [Contract] **[Policy]** all services, in order to be covered by (Carrier), must be performed either by a {participating} Primary Care Physician or by the {participating} specialist, hospital or other provider as authorized by prior written referral from the {participating} Primary Care Physician **[or Care Manager].]**

[6. **[If applicable,]** Applicant agrees to make payment directly to health care providers, such copayments as are provided for in the Individual [Contract] **[Policy].]**

[7. Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular **[Health** Center], Primary Care Physician or other health care provider.]

[8. Applicant acknowledges that (Carrier's) participating providers, including all participating primary care physicians, are independent contractor and are not agents or employees of (Carrier).]

Please print in ink all information requested on this application.

1. Eligible Persons to be Enrolled (Note: Dependent children may be covered under their parent's contract only while unmarried and until they attain age (20) 19 or 23, if full-time students. Unmarried, handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.)

This section must be completed in its entirety.

			BIRTHDATE			SEX	
LAST NAME	FIRST NAME	MI	MO	DAY	YR	(M or F)	Social Security Number
Applicant 1. ☐ Add ☐ Remove							__/__/__-__/__-__/__/__/__
Spouse 2. ☐ Add ☐ Remove							__/__/__-__/__-__/__/__/__
Child 3. ☐ Add ☐ Remove							__/__/__-__/__-__/__/__/__
Child 4. ☐ Add ☐ Remove							__/__/__-__/__-__/__/__/__
Child 5. ☐ Add ☐ Remove							__/__/__-__/__-__/__/__/__

*Attach sheet to list additional children. Attach proof if full-time student. Totally disabled dependent children will be covered regardless of age. Attach proof of disability.

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at another address? ☐ Yes ☐ No

If yes, who and at what address?

_____

Explain the circumstances.

_____

If any dependent's last name is different from yours, explain the circumstances.

_____

2. PRIMARY RESIDENCE (Note: You must reside in New Jersey for the majority of a calendar year with the intention of making New Jersey your home and not for temporary purposes.)

Street Apt. City State Zip

TELEPHONE NUMBER

Home ( ) -

Work ( ) -

Best place to call during day: ☐ Home ☐ Work

Are you a resident of the State of New Jersey? ☐ Yes ☐ No

Do you maintain a residence in any other state? ☐ Yes ☐ No

If "Yes", (a) Name of state _____
(b) How much time do you spend there each year? _____

3. COVERAGE (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY FAMILY) IN: (Only one may be selected) [(For Plans B, C, D, and E select one deductible option.)]

[PLAN A	[☐ Indemnity]	[☐ Point of Service]	[☐ Preferred Provider]			
PLAN B	[☐ Indemnity]	[☐ Point of Service]	[☐ Preferred Provider]	Deductible $250 ____	$500 ____	$1000 ____
PLAN C	[☐ Indemnity]	[☐ Point of Service]	[☐ Preferred Provider]	Deductible $250 ____	$500 ____	$1000 ____
PLAN D	[☐ Indemnity]	[☐ Point of Service]	[☐ Preferred Provider]	Deductible $250 ____	$500 ____	$1000 ____
PLAN E	[☐ Indemnity]	[☐ Point of Service]	[☐ Preferred Provider]	Deductible $150 ____	$500 ____	$1000 ____]

[HMO Plan [$10] $15 [$20] copayment.]

Type of Contract: ☐ Single
☐ Family
☐ Parent & Child(ren)
☐ Husband/Wife

Type of Activity:

☐ New Subscriber

☐ Converting from existing (carrier) plan
ID # _____

☐ Add/Remove Dependent
Reason _____
Date of Event _____

☐ Name Change from _____ to _____

[☐ Change of Primary Care Physician or {GYN} Gynecologist]

[☐ Change of Health [Care] Center from _____ to _____]

[☐ Change of Primary Care Physician at Health [Care] Center]

☐ Withdrawal From Coverage
Date of Event _____

SELECT THE PAYMENT PLAN YOU DESIRE

☐ Monthly [☐ Quarterly] [☐ Semi-Annually]

[PAYMENT MODE:
☐ Check
☐ Money Order
☐ Credit Card Type _____ No. _____ Exp. Date _____
☐ Automatic Bank Draft (attach voided check)
☐ Other _____ Amount $ _____]

4. OTHER HEALTH CARE COVERAGE {Please note that} [Note: In some situations, if you are eligible for or have other health benefits coverage, you are not eligible for this [policy] [coverage]. If you or other family members become eligible for or become covered under other health benefits coverage, after the date of this application, you must notify us as soon as possible, however no later than the effective date of such other coverage.]

Are you employed? ☐ Yes ☐ No	If yes, please give name and address of your employer.
Are you eligible for other health benefits coverage? (i.e., coverage under your employer's health benefits coverage, Medicare or Medicaid) ☐ Yes ☐ No	

If yes, give name and policy no. of other carrier or type of coverage.
Are other family members eligible for coverage? If yes, specify.
Do you or other family members currently have any other health care coverage? ☐ Yes ☐ No
If yes, give name and policy/certificate no. of other carrier, initial effective date of coverage and specify those covered by the policy/certificate:
Are you replacing existing coverage? ☐ Yes ☐ No
If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy.
[Have you or your dependents ever been a member of [carrier]?]
[If yes, under what name and social security no.?]
[Where? [carrier] of:]

5. PROVIDER SELECTION

	FULL NAME OF PRIMARY CARE PHYSICIAN AND OFFICE ID NO.	HEALTH CENTER* (if applicable)	[GYNECOLOGIST OFFICE NO.]	ESTABLISHED PATIENT	PRIMARY CARE PHYSICIAN CHANGE	HEALTH CENTER CHANGE
1. Applicant				☐ Yes ☐ No	☐	☐
2. Spouse				☐ Yes ☐ No	☐	☐
3. Child				☐ Yes ☐ No	☐	☐
4. Child				☐ Yes ☐ No	☐	☐
5. Child				☐ Yes ☐ No	☐	☐
[Statewide Physician Network ☐ Health Center ☐]						

*When selecting Health Center option, please also select a Primary Care Physician from among the Health Center doctors.

[5.][6.] AUTHORIZATION AND CERTIFICATION

I hereby apply to (carrier) for coverage for any eligible dependents listed above and myself.

I understand that for the 12 months following the effective date of this [policy] [contract], benefits are not provided for health care services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this [policy] [contract]. (Note: This limitation may not apply if the eligible person transfers from another health benefits plan.)

[[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, (carrier) may pay the health care benefits directly to the provider instead of to me.]

I agree that: (a) any physician, hospital or other provider is authorized to provide to (carrier or its assignee) information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to (carrier or its assignee.)

I state that: (a) I am a resident of New Jersey [and reside within the (carrier) service area (if applicable)], (b) the information given on this application is complete to the best of my knowledge and belief and (c) that (carrier) will rely on this information to

determine eligibility. I understand that if I omit or falsify any statement in this application (carrier) can cancel this contract as of the original effective date.

Applicant's Signature: _____ Date Signed: _____

Spouse's Signature: _____ Date Signed: _____

Preparer's Signature: _____ DOI License # _____ Date Signed: _____

NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your {[certificate]} [contract] [policy]. It becomes part of your contract with us.

[6.] [7.] INCOME HOUSEHOLD

Completion of this section is optional. The information will be used for statistical purposes only, in a way that will not identify you personally. This information will not affect your application, acceptance or coverage.

☐ under {$10,000}-$19,999 ☐ $20-{$30,000}$29,999 ☐ $30-{$40,000}$39,999 ☐ $40-{$50,000}$49,999

☐ $50-{$60,000}$59,999 ☐ $60,000 and above

For [Carrier] [Plan] Use Only	[Effective Date]	[Billing]	[Coverage Code]	[Type]	[Pre-Ex]	[Continuous Coverage]	[Transcode]	[ ]

EXHIBIT Q

CERTIFICATION OF COMPLIANCE

Submit this form in triplicate to the IHC Board at the following address: 20 West State Street, CN-325, Trenton, New Jersey 08625. Affiliated Carriers must file separate forms.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name: _____

NAIC#: _____

Respondent's Name: _____

Respondent's Title: _____

Respondent's Address: _____

_____

Respondent's Telephone _____ FAX: _____

2. Compliance

Check all appropriate responses.

____ (a) We are using the following forms which fully comply with the IHC Board's individual health benefits plan forms as set forth in the appropriate Exhibit of the Appendix to N.J.A.C. 11:20:

_____ Plan A / Exhibit A

_____ Plan B / Exhibit B

_____ Plan C / Exhibit C

_____ Plan D / Exhibit D

_____ Plan E / Exhibit E

_____ HMO Plan / Exhibit F

____ (b) Our application form complies with the IHC Board's form as set forth in Exhibit G in the Appendix to N.J.A.C. 11:20.

____ (c) We are using an alternative application form pursuant to N.J.A.C. 11:20-4.1(b) and three copies of said form are hereby being submitted to the IHC Board for approval.

3. PLAN OPTIONS

Complete each relevant section (please use "NA" to indicate when a section is not relevant). Attach additional pages as necessary.

(a) Plans A through E

(1) List all plans to be offered as traditional indemnity contracts, if any.

_____

_____

(2) List all plans to be offered in conjunction with a selective contracting arrangement (defined as N.J.A.C. 11:4-37), if any.

_____

_____

_____

(3) For all plans to be offered in conjunction with a selective contracting arrangement, specify the coinsurance differentials and whether the plan requires election of a primary care physician.

_____

_____

_____

_____

(4) Do the plans provide for direct payment to health care practitioners without assignment? (Note: this option is available only on health service corporation plans and other plans offered in conjunction with selective contracting arrangements.)

_____ Yes _____ No

(5) Do the plans include any of the following as set forth by the IHC Board?

i. Alternate Treatment Features

_____ Yes _____ No

ii. Centers of Excellence Features

_____ Yes _____ No

(b) HMO Plan

(1) Check the copayment options being offered.

☐ $10 (Optional)

☐ $15 (Standard)

☐ $20 (Optional)

(2) Is the in-network prescription drug coverage being offered?

☐ $15 Copayment

☐ 5% Co-insurance

4. CERTIFICATION

I, the undersigned, certify that this completed form is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.

_____ Date

_____ Signature

_____ Title

ENVIRONMENTAL PROTECTION

(a)

NEW JERSEY WATER SUPPLY AUTHORITY

Schedule of Rates, Charges and Debt Service Assessments for the Sale of Water from the Delaware and Raritan Canal-Spruce Run/Round Valley Reservoirs System

Proposed Amendments: N.J.A.C. 7:11-2.2, 2.3, 2.4, 2.10 and 2.12

Authorized By: Robert C. Shinn, Jr., Chair, New Jersey Water Supply Authority and Commissioner, Department of Environmental Protection.

Authority: N.J.S.A. 58:1B-7.

DEP Docket Number: 52-94-11/502.

Proposal Number: PRN 1994-657.

In accordance with N.J.A.C. 7:11-2.12(a)4, a **pre-public hearing meeting** concerning this proposal will be held on:

Tuesday, January 3, 1995 at 10:00 A.M.
New Jersey Water Supply Authority Administration Building
1851 State Highway 31
Clinton, New Jersey

A **public hearing** concerning this proposal will be held on:

Thursday, February 2, 1995 at 10:00 A.M. to close of comments at the
New Jersey Water Supply Authority Canal Office
Route 579 (Exit 2, Interstate Route I-95)
Ewing Township, Mercer County, New Jersey

Submit written comments, identified by the Docket Number given above, on or before March 13, 1995 to:

Janis Hoagland, Esq.
Administrative Practice Officer
Office of Legal Affairs
Department of Environmental Protection
401 East State Street, 4th Floor
CN 402
Trenton, New Jersey 08625

and

Thomas G. Baxter, P.E.
Acting Executive Director
New Jersey Water Supply Authority
1851 State Highway 31
Post Office Box 5196
Clinton, New Jersey 08809

The **Basis and Background document,** which is available from the Authority at the address given below, explains in further detail the financial justification for the proposed revised rate schedule.

Thomas G. Baxter, P.E.
Acting Executive Director
New Jersey Water Supply Authority
1851 State Highway 31
Post Office Box 5196
Clinton, New Jersey 08809

The agency proposal follows:

Summary

The New Jersey Water Supply Authority (Authority) is proposing to amend its Schedule of Rates, Charges and Debt Service Assessments for the Sale of Water from the Delaware and Raritan Canal—Spruce Run/Round Valley Reservoirs System (System), to cover operation and maintenance costs for the fiscal year commencing July 1, 1995.

The General Rate Schedule for Operations and Maintenance in N.J.A.C. 7:11-2.2 was last adjusted effective July 1, 1994 (decreased from $115.66 to $114.69 per million gallons (MG)) to cover the operation expenses of the System.

Projected operating costs for fiscal year 1996 now indicate that an operations and maintenance rate component of $118.04 (increased) will be needed starting July 1, 1995. Most of the increased operations and maintenance expenses are due to the projected increases in employee salaries and benefits; electricity; vehicular fuel; maintenance supplies; safety equipment; insurance premiums; telephone; and printing and office expenses. The operations and maintenance expense component sales base for fiscal year 1995 was 151.016 million gallons per day (MGD). The Authority anticipates that the applicable operations and maintenance sales base for Fiscal Year 1996 will be 150.952 MGD (decreased).

The Debt Service Assessment rate for the 1969 bonds involved in the construction of the Spruce Run/Round Valley Reservoir System Outlet Pipeline and Dam Rehabilitation Projects was based on a sales base of 150.558 MGD for fiscal year 1995. The Authority anticipates that the applicable sales base for fiscal year 1996 will be 150.457 MGD (decreased). Application of this sales base results in no change in the per MG rate of $14.01 per MG for the 1969 bonds (N.J.A.C. 7:11-2.3(b)).

The Debt Service Assessment rate for the 1981 water supply bond funds used to finance the removal of sediment from 32 miles of the Delaware and Raritan Canal was previously adjusted July 1, 1994 (Fiscal Year 1995) based on a sales base of 150.983 MG. The Authority anticipates that the applicable sales base for fiscal year 1996 will be 150.882 MGD (decreased). This adjustment in the sales base combined with an increase in the payment due to the State Treasurer results in a rate of $33.48 (increased) per MG for the 1981 bonds starting July 1, 1995 (N.J.A.C. 7:11-2.3(c)).

The Debt Service Assessment rate for the 1988 water systems revenue bonds issued to finance the Authority's recent capital improvement program was based on a sales base of 150.946 MGD for fiscal year 1995. The Authority anticipates that the applicable sales base for fiscal year 1996 will be 150.882 MGD (decreased). Application of this sales base results in a rate of $57.38 (increased) per MG for fiscal years 1996 and 1997 before decreasing to $57.20 (decrease) for fiscal years 1998 and 1999.

In addition to the existing rate components mentioned above, the Authority established a new "Capital Fund Assessment" (N.J.A.C. 7:11-2.4(b)) starting July 1, 1994. This new component is used to fund the Authority's current Capital Improvement Program (January, 1994-June, 1999), which includes 16 projects to rehabilitate various culverts, canal embankments, and flow control structures, without incurring long term debt. The Capital Fund Assessment will increase from $10.00 to $15.00 per million gallons effective July 1, 1995, to $20.00 per million gallons on July 1, 1996, and to $25.00 per million gallons on July 1, 1998 as previously scheduled.

Technical changes will also be made to the text of N.J.A.C. 7:11-2.12 which will include the deletion of the Department of Public Advocate, Division of Rate Counsel to be replaced with the Department of the Treasury, Office of the Rate Payer Advocate to reflect recent organizational changes in the State Government.

Final action on the rate adjustment is scheduled for the April 3, 1995 meeting of the Authority.

Social Impact

The proposed amendments will have minimal social impact. The proposed amendments represent the Authority's efforts to ensure that rates for raw water withdrawn, diverted or allocated from the Delaware and Raritan Canal and the Spruce Run/Round Valley Reservoir Complex are equitably assessed and sufficient to provide the revenues required by the Authority.

The 11 billion gallon capacity Spruce Run Reservoir and the 55 billion gallon capacity Round Valley Reservoir in Hunterdon County in conjunction with the sixty mile long Delaware and Raritan Canal in Hunterdon, Mercer, Somerset, and Middlesex Counties provide both active and passive recreational opportunities to the public in addition to a basic raw water supply for approximately 1,200,000 individuals living in central New Jersey.

Economic Impact

The proposed adjustments to the rate schedule will result in a net increase in the total charge for the raw water supplied from the System ranging from $8.41 in fiscal year 1996 to $18.41 in fiscal year 1999 per MG. It is estimated that the annual impact of the proposed wholesale water rate increase on the typical household will amount to $.84 in fiscal year 1996 provided these increased costs are passed through by the wholesale water customers without further fees.

Environmental Impact

The adequate financing of systems upkeep and operation, which is provided by the proposed amendments, will result in a positive environmental impact. Properly maintained Authority systems and operations protect not only the water users but also the surrounding environment of the Spruce Run/Round Valley Reservoirs and the Delaware and Raritan Canal.

The reservoirs and canal also provide habitat for many species of waterfowl and wildlife in an increasingly urbanized region of the State.

The Authority's Raritan Basin System is capable of supplying a dependable water supply of 225 MGD throughout a re-occurrence of the worst drought of record while still maintaining adequate river flows through release of stored waters to support the ecological systems and wildlife which are dependent upon adequate stream flows in the River Basin.

Regulatory Flexibility Statement

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Authority has determined that these amendments will not impose reporting, recordkeeping or other compliance requirements on small businesses because the amendments affect only the rate charged to users for water purchased from the Authority. The water companies which contract to purchase water from the Authority and which are impacted by these rules do not qualify as "small businesses" pursuant to N.J.S.A. 52:14B-16 et seq.

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

7:11-2.2 General Rate Schedule for Operations and Maintenance

(a) The General Rate Schedule for Operations and Maintenance per million gallons listed at (b) below is based on estimated annual operations and maintenance expenses consisting of all current costs, obligations and expenses of, or arising in connection with, the operation, maintenance and administration of the System, and minor additions or improvements thereof or thereto, or the performance of any water purchase contract, including, but not limited to, all of the following:

1.-7. (No change.)

8. Any other current costs, expenses or obligations required to be paid by the Authority under the provision of any agreement or instrument relating to bonds, other indebtedness of the Authority or by law. The current sales base of [151.016] **150.952** million gallons per day has been used in setting the rate listed at (b) below.

(b) General Rate Schedule for Operations and Maintenance:

Allocation	Rate/Million Gallons
Million Gallons per Day (MGD)	[$114.69] **$118.04**

7:11-2.3 Debt Service Assessments

(a) (No change.)

(b) The Debt Service Assessment rate for the 1969 Water Conservation Bonds shall be based on a sales base of [150.521] **150.457** million gallons per day. This Debt Service Assessment rate does not apply to Delaware and Raritan Canal customers in the Delaware River Basin.

1. 1969 Water Conservation Bond Funds:

Period	Allocation	Rate/Million Gallons
[7/1/94] **7/1/95** to 6/30/2002	Million Gallons per Day (MGD)	$14.01

(c) 1981 Water Supply Bond funds were borrowed from the State Treasurer to retire the tax exempt commercial paper used for temporary financing of the Delaware and Raritan Canal sediment removal program. The following Debt Service Assessment rate, based on a sales base of [150.946] **150.882** million gallons per day, in addition to that included in (b) above, will be applied to all customers.

Period	Allocation	Rate/Million Gallons
[7/1/94] **7/1/95** to 10/30/2006	Million Gallons per Day (MGD)	[$33.42] **$33.48**

(d) The following Debt Service Assessment rate for the 1988 Water System Revenue Bonds, based on a sales base of [150.946] **150.882** million gallons per day, in addition to that included in (b) and (c) above, will be applied to all customers:

Period	Allocation	Rate/Million Gallons
[7/1/94] to 6/30/95]	[Million Gallons per Day (MGD)]	[$57.38]
7/1/95 to [6/30/98] **6/30/97**	Million Gallons per Day (MGD)	[$57.34] **$57.38**
7/1/97 to 6/30/99	**Million Gallons per Day (MGD)**	**$57.20**

7:11-2.4 Capital Fund Component

(a)-(b) (No change.)

(c) Capital Fund Assessment

Period	Allocation	Rate/Million Gallons
[7/1/94 to 6/30/95	Million Gallons per Day (MGD)	$10.00]
7/1/95 to 6/30/96	Million Gallons per Day (MGD)	$15.00
7/1/96 to 6/30/98	Million Gallons per Day (MGD)	$20.00
7/1/98 to 6/30/99	Million Gallons per Day (MGD)	$25.00

7:11-2.10 Standby charge

(a) A user classified under standby service, as provided in N.J.A.C. 7:11-2.9 above, shall pay a monthly minimum charge based on the capacity of the user's withdrawal system as specified below. Said purchaser shall also pay for all water withdrawn during the month in excess of such monthly standby charge, based on charges as set forth under N.J.A.C. 7:11-2.2, 2.3 and 2.4.

Note: MGD = million gallons daily; GPM = gallons per minute.

1. For Delaware and Raritan Canal Standby Contracts within the Delaware River Basin:

Maximum withdrawal capacity	Charge per month
Each 1 MGD (700 GPM) or fraction thereof.	[$114.69] **$118.04** plus annual debt service assessment rates for 1981 Water Supply Bonds, 1988 Water System Revenue Bonds and Capital Fund Component.

2. For Standby Contracts within the Raritan River Basin:

Maximum withdrawal capacity	Charge per month
Each 1 MGD (700 GPM) or fraction thereof.	[$114.69] **$118.04** plus annual debt service assessment rate for 1969 Water Conservation Bonds, 1981 Water Supply Bonds, 1988 Water System Revenue Bonds and Capital Fund Component.

7:11-2.12 Procedures for rate adjustments

(a) Prior to adopting an adjustment in the Schedule or the Sales Bases established in this subchapter, the Authority shall comply with the following ratemaking procedures and schedule:

1. Official Notice: Official notice and an explanation outlining the need for the proposed adjustment to the Schedule or the Sales Bases shall be given to all contractual water customers; the Department of [Public Advocate, Division of Rate Counsel] **the Treasury, Office of Rate Payer Advocate**; and other interested parties at least six months prior to the proposed effective date.

2. Supporting documents and financial records: All appropriate supporting documents and financial records of the Authority in support of the proposed adjustment shall either be supplied to all contractual water customers; the Department of [Public Advocate, Division of Rate Counsel] **the Treasury, Office of Rate Payer Advocate**; and other interested parties upon request, or shall be made available for review at the Authority's offices in Clinton, New Jersey at the time official notice of the proposed rate adjustment is given. This information shall be deemed to be part of the record of the proceedings for purposes of preparing the hearing officer's report required under (a)7 below.

3. Requests for additional information: The contractual water customers and the Department of [Public Advocate, Division of Rate Counsel] **the Treasury, Office of the Rate Payer Advocate** shall be afforded the opportunity to submit written questions and requests for additional data prior to the time of the meeting required under (a)4 below. The Authority staff shall provide written answers to the questions and supply the additional data requested prior to the meeting.

4. Meeting with contractual customers and the [Public Advocate, Division of Rate Counsel] **Office of Rate Payer Advocate**: After sending official notice to the contractual water customers and the [Public Advocate, Division of Rate Counsel] **Department of the Treasury, Office of Rate Payer Advocate**, regarding the proposed rate adjustment, Authority staff shall schedule a meeting to occur within 45 days with representatives from the contractual water customers and the [Public Advocate's office] **Office of Rate Payer Advocate** in order to present and explain the proposal.

i. At that time, contractual water customers and the [Public Advocate, Division of Rate Counsel] **Office of Rate Payer Advocate**, will be invited to submit written questions which shall be put into the hearing record and which will be answered by Authority staff at the public hearing.

ii. (No change.)

5. Public hearing: After meeting with the contractual customers and after giving sufficient opportunity for submission of written questions on the proposed rate adjustment, a public hearing shall be held, at which one or more members of the Authority shall serve as hearing officer(s). The public hearing agenda shall include, but not be limited to, the following:

i. (No change.)

ii. Staff answers to the questions raised prior to the hearing by the contractual water customers and the [Public Advocate, Division of Rate Counsel] **Office of Rate Payer Advocate**;

iii. Oral statements, written statements and any supporting evidence are to be presented and entered into the record by all interested parties including the contractual water customers, the [Public Advocate, Division of Rate Counsel] **Office of Rate Payer Advocate**, intervenors who are judged by the hearing officer(s) to meet the criteria established in (a)5iv below, and any other party of interest;

iv. (No change.)

(1)-(2) (No change.)

(3) The [Public Advocate, Division of Rate Counsel] **Department of the Treasury, Office of Rate Payer Advocate**, shall be deemed a qualified intervenor for purposes of the public hearing.

v. (No change.)

vi. Responses from staff.

(1) In the event that a response cannot be immediately given at the hearing, then a written response shall be prepared within 10 working days after the public hearing, and a copy of that written response shall be provided to all contractual water customers, the [Public Advocate, Division of Rate Counsel] **Office of Rate Payer Advocate**, and attendees at the hearing and made a part of the hearing record.

(2) Within 10 working days after receipt of the answer, contractual water customers, the [Public Advocate, Division of Rate Counsel] **Office of Rate Payer Advocate**, and attendees will be permitted to respond in writing to the answers of the staff for the record.

6.-7. (No change.)

(a)

NEW JERSEY WATER SUPPLY AUTHORITY

Schedule of Rates, Charges and Debt Service Assessments for the Sale of Water from the Manasquan Reservoir Water Supply System

Proposed Amendments: N.J.A.C. 7:11-4.3, 4.4, 4.9 and 4.13

Authorized By: Robert C. Shinn, Jr., Chair, New Jersey Water Supply Authority and Commissioner, Department of Environmental Protection.

Authority: N.J.S.A. 58:1B-7.

DEP Docket Number: 51-94-11/501.

Proposal Number: PRN 1994-658.

In accordance with N.J.A.C. 7:11-4.13(a)4, a **pre-public hearing meeting** concerning this proposal will be held on:

Wednesday, January 11, 1995 at 10:00 A.M.
New Jersey Water Supply Authority
Manasquan Reservoir System Administration Building
Hospital Road
Wall, New Jersey

A **public hearing** concerning this proposal will be held on:

Wednesday, February 8, 1995 at 10:00 A.M. to close of comments
New Jersey Water Supply Authority
Manasquan Reservoir System Administration Building
Hospital Road
Wall, New Jersey

Submit written comments, identified by the Docket Number given above, on or before March 17, 1995 to:

Janis Hoagland, Esq.
Administrative Practice Officer
Office of Legal Affairs
Department of Environmental Protection
401 East State Street, 4th Floor
CN 402
Trenton, New Jersey 08625
and
Thomas G. Baxter, P.E.
Acting Executive Director
New Jersey Water Supply Authority
1851 State Highway 31
Post Office Box 5196
Clinton, New Jersey 08809

The **Basis and Background document**, which is available from the Authority at the address given below, explains in further detail the financial justification for the proposed revised rate schedule:

Thomas G. Baxter, P.E.
Acting Executive Director
New Jersey Water Supply Authority
1851 State Highway 31
Post Office Box 5196
Clinton, New Jersey 08809

The agency proposal follows:

Summary

The New Jersey Water Supply Authority (Authority) is proposing to amend its Schedule of Rates, Charges and Debt Service Assessments for the Sale of Water from the Manasquan Reservoir Water Supply System (System), to cover operation and maintenance costs for the fiscal year commencing July 1, 1995. It is also proposing to adjust its existing debt service assessment on system loans effective July 1, 1995.

The operations and maintenance expense component in N.J.A.C. 7:11-4.3 was last adjusted effective July 1, 1994 (increased from $323.93 to $349.23 per million gallons, (MG)) to cover the operation expenses of the System.

Projected operating costs for fiscal year 1996 indicate that an operations and maintenance rate component of $379.89 (increased) will be needed starting July 1, 1995. The projected operations and maintenance expenses for employee salary requirements; special and professional services; utility electrical energy costs; printing and office supplies; insurance; and capital equipment costs have increased for fiscal year 1996. The principal increases in the projected operating expenses result from (a) salary increases for fiscal year 1996, (b) an anticipated three percent increase in electrical energy costs, (c) an anticipated seven percent increase in insurance premiums, and (d) increased overhead charges for support services from the Authority's headquarters in Clinton, New Jersey. However, these increased costs are somewhat offset by decreases in the projected costs for maintenance of equipment; and in-lieu tax payments. The Authority projects a net decrease in miscellaneous revenues/credits during fiscal year 1996 which furthers the net increase in the overall Operations and Maintenance budget for fiscal year 1996. The operations and maintenance expense component sales base will remain unchanged at 16.097 million gallons per day (MGD) for fiscal year 1996.

The debt service cost in N.J.A.C. 7:11-4.4 will decrease from $765.75 to $761.86 per million gallons on July 1, 1995.

The calculation of the operations and maintenance component as well as the debt service assessments is based upon a contractual sales base of 16.097 MGD as of July 1, 1995.

Technical changes will also be made to the text of N.J.A.C. 7:11-4.13 which will include the deletion of the Department of Public Advocate, Division of Rate Counsel to be replaced with the Department of the Treasury, Office of the Rate Payer Advocate, and the deletion of the Board of Regulatory Commissioners to be replaced with the Board of Public Utilities, to reflect recent organizational changes in the State Government to be found at 26 N.J.R. 2171.

Social Impact

The proposed amendments will have a positive social impact and effect. The proposed amendments represent the New Jersey Water Supply Authority's efforts to ensure that rates for the untreated water purchased from the Manasquan Reservoir System are equitably assessed to all purchasers and sufficient to provide the revenues required by the Authority.

This four billion gallon capacity reservoir provides a needed water supply to keep pace with the continuing growth in Monmouth County while reducing the dependence of water purveyors on the stressed ground water resources of the region.

Economic Impact

The proposed rate adjustments will result in a total charge for the uninterruptible untreated water supply from the Manasquan Reservoir System of $1,141.75 per million gallons ($379.89 for operation and maintenance plus $761.86 for debt service) starting July 1, 1995.

The proposed adjustments to the rate schedule will result in a net increase of $26.77 per million gallons in the total charge for the raw water supplied from the System effective July 1, 1995. It is estimated that the annual impact of the proposed wholesale water rate adjustment on the typical household will amount to a $2.67 increase provided the

increased costs are passed through by the wholesale water customers without further fees.

Environmental Impact

The adequate financing of upkeep and operation of the Manasquan Reservoir System, which is provided by the proposed amendments, will result in a positive environmental impact. Sixty percent of the existing water supply in Monmouth County was derived from stressed ground water resources. The Manasquan Reservoir System relieves the use of a portion of the existing ground water supply and meets the needs of a developing area. This water supply system has a very important and positive environmental impact since its operation reduces the stress on the valuable ground water resources of the region by providing an alternate surface water supply. By reducing the pumping of ground water, salt water intrusion will be limited and present ground water levels will not be further reduced.

The 30 million gallon per day water supply which the system can provide helps to ameliorate the urgent need to protect the region's threatened ground water resources from further depletion. In addition, the 740 acre Manasquan Reservoir provides for the protection of waterfowl and wildlife in the region through several protected wetland sites for the rearing of waterfowl and wildlife.

Regulatory Flexibility Statement

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Authority has determined that this rule adjustment will not impose reporting, recordkeeping, or other compliance requirements on small businesses because the rule proposal affects only municipalities and major water purveyors, none of which qualify as small businesses as defined in N.J.S.A. 52:14B-16 et seq.

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

7:11-4.3 Operations and maintenance expense component

(a)-(b) (No change.)

(c) Operations and maintenance expense component:

Effective Date	Rate/Million Gallons (based upon a 16.097 mg per day sales base)
July 1, [1994]**1995**	[$349.23]**$379.89**

7:11-4.4 Debt service cost component

(a) (No change.)

(b) The following Debt Service rates, based on a sales base of 16.097 million gallons per day, apply to all water purchasers who entered into a water purchase contract before July 1, 1990, the date upon which the Authority commenced operation of the Manasquan Reservoir System (Initial Water Purchase Contract) and began to make uninterruptible service available to the purchasers ("System Operation Date").

Period	Rate/Million Gallons
7/1/[94]**95** to 6/30/[95]**96** (Coverage 120 percent)	[$765.75]**$761.86**

(c)-(d) (No change.)

7:11-4.9 Standby charge

A purchaser classified under standby service shall pay a monthly minimum charge based on the capacity of the purchaser's withdrawal system as specified below. Said purchaser shall also pay for all water withdrawn during the month in excess of such monthly standby charge based on charges as set forth under N.J.A.C. 7:11-4.3 and 4.4.

Maximum withdrawal capacity	Charge per month
Each 1 MGD (700 GPM) or fraction thereof	[$349.23] **$379.89** plus annual debt service assessment rate established in N.J.A.C. 7:11-4.4

7:11-4.13 Procedures for rate adjustments

(a) Prior to amending the schedule of rates, charges and debt service assessments established by this subchapter, the Authority shall:

1. Provide notice and an explanation outlining the need for the proposed rate adjustment to all purchasers; the Department of [Public Advocate, Division of Rate Counsel] **the Treasury, Office of the Rate Payer Advocate**; the Board of [Regulatory Commissioners] **Public Utilities** and other interested persons at least six months prior to the proposed effective date. This notice and explanation shall be deemed to be part of the record of the proceedings.

2. Provide supporting documents and financial records of the Authority, at the Authority's cost, in support of the proposed adjustment to all purchasers; the Department of [Public Advocate, Division of Rate Counsel] **the Treasury, Office of the Rate Payer Advocate;** the Board of [Regulatory Commissioners] **Public Utilities** and other interested persons upon request, and make such documents and records available for review at the Authority's offices in Clinton, New Jersey at the time notice of the proposed amendment to the rates is given. These supporting documents and financial records shall be deemed to be part of the record of the proceedings for purposes of preparing the hearing officer's report required under (a)9 below;

3. Afford purchasers, the Department of [Public Advocate, Division of Rate Counsel] **the Treasury, Office of the Rate Payer Advocate** and the Board of [Regulatory Commissioners] **Public Utilities** and other interested persons the opportunity to submit written questions and requests for additional data prior to the time of the meeting required under (a)4 below. The Authority staff shall provide written answers to the questions and supply the additional data requested prior to the meeting;

4. Schedule a meeting with the purchasers, the Department of [Public Advocate, Division of Rate Counsel] **the Treasury, Office of the Rate Payer Advocate** and the Board of [Regulatory Commissioners] **Public Utilities** and other interested persons within 45 days after sending them notice of the proposed amendments to the rate schedule regarding the proposed amendments:

i. At the meeting the purchasers, the Department of [Public Advocate, Division of Rate Counsel] **the Treasury, Office of the Rate Payer Advocate**, and the Board of [Regulatory Commissioners] **Public Utilities** and other interested persons will be invited to submit written questions which will be put into the hearing record and which will be answered by Authority at the public hearing;

ii. (No change.)

5. Hold a public hearing on the proposed rate adjustment. One or more members of the Authority will serve as the hearing officer. The public hearing agenda shall include, but not be limited to:

i. (No change.)

ii. The Authority's answers to the questions raised prior to the hearing by the purchasers, the [Public Advocate, Division of Rate Counsel] **Department of the Treasury, Office of the Rate Payer Advocate**, the Board of [Regulatory Commissioners] **Public Utilities** and other interested persons;

iii. (No change.)

iv. Questions of the Authority by the purchasers, the [Public Advocate, Division of Rate Counsel] **Department of the Treasury, Office of the Rate Payer Advocate**, the Board of [Regulatory Commissioners] **Public Utilities** and any interested persons on any aspect of the need for, the basis of, or any provision of the proposed rate adjustment. Follow up questions relative to the answers of the Authority may also be directed to the Authority during the public hearing;

6. Attempt to answer all questions raised at the public hearing. In the event that a response cannot be immediately given at the public hearing, then a written response shall be prepared within 10 working days after the public hearing, and a copy of that written response will be provided to all contractual water purchasers, the [Public Advocate, Division of Rate Counsel] **Department of the Treasury, Office of the Rate Payer Advocate**, Board of [Regulatory Commissioners] **Public Utilities** and attendees at the hearing and made a part of the hearing record;

7. Permit, within 10 working days after receipt of the answer, contractual water purchaser, the [Public Advocate, Division of Rate Counsel] **Department of the Treasury, Office of the Rate Payer Advocate**, the Board of [Regulatory Commissioners] **Public Utilities** and attendees will be permitted to respond in writing to the answers of the staff for the record;

8.-9. (No change.)

(b) (No change.)

(a)

WATER SUPPLY ELEMENT

Water Supply Allocation Rules

Proposed Readoption with Amendments: N.J.A.C. 7:19

Proposed Readoption and Recodification with Amendments: N.J.A.C. 7:19A-1 through 7 recodified as 7:19-10 through 17, and N.J.A.C. 7:19B recodified as 7:19-9

Proposed New Rules: N.J.A.C. 7:19-8 and 18

Proposed Amendments: N.J.A.C. 7:14-8.1, 8.3, 8.4 and 8.15

Authorized by: Robert C. Shinn Jr., Commissioner, Department of Environmental Protection.

Authority: N.J.S.A. 58:1A-1 et seq., 58:2-1 et seq., 58:4A-1 et seq., 58:11-59 et seq., and 58:12A-1 et seq.

DEP Docket Number: 49-94-11/18.

Proposal Number: PRN 1994-653.

A **public hearing** concerning this proposed readoption with amendments will be held on:

Friday, January 6, 1995 at 10:00 A.M.
NJDEP Public Hearing Room, 1st Floor
401 E. State Street
Trenton, New Jersey

Submit written comments, identified by the Docket Number given above, by January 18, 1995 to:

Janis E. Hoagland, Esq.
Office of Legal Affairs
Department of Environmental Protection
CN 402
Trenton, New Jersey 08625-0402

The agency proposal follows:

Summary

The Department of Environmental Protection (Department) is responsible for ensuring a safe and adequate supply of water pursuant to the Water Supply Management Act (Act), N.J.S.A. 58:1A-1 et seq. and therefore must plan for, administer and manage the State's water resources. Under the Act, the Department is directed to provide a regulatory program to ensure that the ground and surface water supplies of the State are managed in a way that protects their quality and quantity, while ensuring the public's health and safety. The water supply allocation permitting program is the central mechanism through which many of the water supply management objectives of the Department are realized.

Pursuant to the requirements of Executive Order No. 66(1978), N.J.A.C. 7:19 is scheduled to expire on February 26, 1995. The Department has reviewed the current rules and determined that they remain necessary and adequate, except as noted below in the discussion of proposed changes. The Department proposes to readopt, without change, the rules at N.J.A.C. 7:19-5 implementing what is commonly referred to as the Small Water Company Takeover Act, N.J.S.A. 58:11-59 et seq., and is proposing to readopt and recodify, without change, the Emergency Water Supply Allocation Plan Regulations from N.J.A.C. 7:19A to N.J.A.C. 7:19-10 through 17, and the Water Emergency Surcharge Schedule Rules from N.J.A.C. 7:19B to N.J.A.C. 7:19-9. The enforcement provisions of the Water Supply Management Act which were previously contained in N.J.A.C. 7:14-8 are proposed to be incorporated into a new subchapter, N.J.A.C. 7:19-18. The rules governing water supply allocation permits and excess diversions, pursuant to N.J.S.A. 58:1A-1 et seq., 58:2-1 et seq., 58:12A-1 et seq., and 58:13D-9 are being proposed for readoption with amendments as described below.

The proposed readoption and recodification of N.J.A.C. 7:19B to N.J.A.C. 7:19-9 and N.J.A.C. 7:19A to N.J.A.C. 7:19-10 through 17 reorganizes the existing rules by which the Department plans for, administers, and manages the State's water resources under conditions which pose or have the potential to develop into water supply or water quality emergencies. Proposed N.J.A.C. 7:19-9 provides for the development and adoption of a water surcharge rate schedule to be utilized in the event of a water emergency. Such a rate schedule is intended to provide a financial incentive to encourage water conservation and reduce consumption during a water emergency. Proposed N.J.A.C. 7:19-10 through 17 contain the rules governing the management of the State's waters during drought warnings, water supply emergencies and water quality emergencies severe enough to constitute water supply emergencies. To facilitate the incorporation of chapters 19A and 19B into chapter 19, the Department is proposing amendments to delete sections already adequately covered in chapter 19 and to make technical revisions to ensure that citations and certain references are consistent with the recodification. The recodification is proposed as follows:

Current citation		Proposed citation
7:19A-1	General Provisions	Repealed
7:19A-2	Powers of the Commissioner During a State of Water Emergency	7:19-10
7:19A-3	General Powers of the Department	7:19-11
7:19A-4	Water Emergency Task Force	7:19-12
7:19A-5	Priority-Based Phase System of Water Restrictions	7:19-13
7:19A-6	Industrial Curtailment Strategy	7:19-14
7:19A-7	Penalties	Repealed
7:19A-8	Emergency Water Transfer Pricing	7:19-15
7:19A-9	Hardship Exemption Procedures	7:19-16
7:19A-10	Department Orders	7:19-17
7:19B-1.1	Scope and authority	7:19-9.1
7:19B-1.2	Purpose	7:19-9.2
7:19B-1.3	Definitions	7:19-1.3
7:19B-1.4	Applicability	Repealed
7:19B-1.5	Establishment of water emergency surcharge schedule	7:19-9.3
7:19B-1.6	Submission of water emergency surcharge schedule; quarterly report	7:19-9.4
7:19B-1.7	Collection of water emergency surcharge; water emergency fund	7:19-9.5
7:19B-1.8	Exemption from the water emergency surcharge schedule	7:19-9.6
7:19B-1.9	Penalties	Repealed

The proposed amendments described below include several major changes to the current water supply allocation rules. The definitions for subchapters 3 and 4, and new subchapters 8 through 17, have been consolidated in subchapter 1. Since the Department intends to incorporate subchapters 5 and 6 into the Safe Drinking Water Act Rules at N.J.A.C. 7:10 when those rules are proposed for readoption with amendments in early 1995, the definitions in those subchapters have not been moved.

The Department is proposing to establish two categories of permits-by-rule. The first is a short-term water use permit-by-rule for diversions of greater than 100,000 gallons of water per day for fewer than 31 days in a 365 day period. This kind of diversion was previously administered through the short term water use notification and report. The second is a permit-by-rule for temporary construction-related dewatering in excess of 100,000 gallons of water per day for more than 30 days from contained areas such as coffer dams. Both of these permits-by-rule are being proposed in order to simplify the regulatory process and reduce the amount of Departmental oversight, while still ensuring that the water resources are adequately protected.

Current N.J.A.C. 7:19-2.3 and 2.4, dealing with additional application requirements for public water supplies, are being proposed for deletion as they are not necessary in the revised permitting scheme. A new N.J.A.C. 7:19-2.3 is being proposed, which sets forth the simplified application requirements for temporary dewatering permits.

A new subchapter, N.J.A.C. 7:19-8, is being proposed to implement the July 1993 amendments to the Water Supply Management Act concerning areas of critical water supply concern. The subchapter sets forth the procedures to be followed by the Department in establishing and administering areas of critical water supply concern, and sets forth the requirements for permittees located in these areas. Current N.J.A.C. 7:19-6.10 to 12, dealing with critical areas, are being proposed for repeal and are to be incorporated into the new subchapter 8, as appropriate.

The Department is also proposing amendments setting forth the procedures to be followed for minor permit modifications, including permit name and/or ownership changes, N.J.A.C. 7:19-1.5(b); criteria for establishing passing flow requirements, N.J.A.C. 7:19-1.6(e); emergency diversions from unpermitted public community supply sources, N.J.A.C. 7:19-1.7(d); and for transferring base allocations and water credits,

N.J.A.C. 7:19-8.7. Throughout the rules information has been consolidated into the appropriate subchapters, sections and subsections to improve organization and readability. In addition, all penalty provisions are consolidated in proposed N.J.A.C. 7:19-18.

The enforcement provisions for the Act are currently codified at N.J.A.C. 7:14-8. N.J.A.C. 7:14-8 was originally intended to provide enforcement provisions for violations of the Water Pollution Control Act. However, the enforcement provisions for a number of other environmental statutes are also contained within N.J.A.C. 7:14-8. For ease of use, the Department proposes to move the enforcement provisions pertaining to the Water Supply Management Act from N.J.A.C. 7:14-8 to N.J.A.C. 7:19-18 since N.J.A.C. 7:19 contains the rules implementing the Act. The proposed enforcement provisions are substantively similar to the current provisions except that the penalties for submitting inaccurate or false information have been reduced. The reduced penalties are consistent with other penalties recently proposed and adopted by the Department.

The following is a summary of the provisions of N.J.A.C. 7:19 proposed for readoption and/or amendment:

Subchapter 1. General Provisions

N.J.A.C. 7:19-1.1, Scope and authority, is being amended to include N.J.S.A. 58:2-1 et seq., Payments to State for Waters Diverted; N.J.S.A. 58:11-59 et seq., commonly known as the Small Water Company Takeover Act; and the emergency water supply allocation provisions of the Water Supply Management Act, N.J.S.A. 58:1A-4. This is being proposed in order to consolidate the water supply allocation rules currently contained in N.J.A.C. 7:19, 7:19A and 7:19B into a single set of regulations. It is anticipated that this will eliminate some of the regulated public's confusion regarding these rules.

N.J.A.C. 7:19-1.2, provides that the rules are to be liberally construed, and is being amended to include all of the statutory authority for the rules.

N.J.A.C. 7:19-1.3, Definitions, is being amended to include definitions previously contained in subchapters 3 and 4, portions of subchapter 6, proposed new subchapter 8, proposed new subchapters 9 through 17 (recodified from N.J.A.C. 7:19A and 19B), proposed new subchapter 18, and the 1993 amendments to the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq. Definitions for the following terms are being proposed: "aquifer storage and recovery well" or "ASR well," "base allocation," "capability to divert 100,000 gallons of water per day," "certified diversion," "diversion source," "emergency well," "facility," "lawful entry," "local use," "local water emergency," "potentiometric surface," "saline water," "salt water," "temporary dewatering permit," "undiminished return," "violator," "water conservation and drought management plan," "water resource," "water usage certification" or "certification," and "well." These definitions are being added to insure the proper understanding of these rules.

The definition of "adverse impact upon wells" is being amended by replacing the wording "forced reduction" with "impaired" as this, in context, more accurately describes the phrase.

The definition of "annual fee" is being amended to include the phrase "regardless if water is diverted from sources included in that permit" to identify that annual fees are charged even if no water is diverted.

The definition of "aquifer" is being amended to more accurately describe the term.

The definition of "area of critical water supply concern" or "critical area" is proposed pursuant to the 1993 amendments to N.J.S.A. 58:1A-1 et seq., the Water Supply Management Act. This replaces the definition of "Water supply critical area" or "critical area" in N.J.A.C. 7:19-6.2 which is proposed to be deleted.

"Confined aquifer" is being revised by deleting the term "confined" from the definition and replacing it with a description of a confined situation.

The definition of "dewatering" is being amended to include wellpoints and sumps to more accurately reflect actual dewatering practice.

The definition of "excess diversion fee" is proposed to replace the definition of "fee" which was contained in subchapter 4. The definition remains unchanged but the words "excess diversion" are being added in order to prevent confusing this fee with the permit fees in subchapter 3.

"Free allowance" is being amended by adding the phrase "for excess diversion fee calculation purposes" in order to identify when the term applies.

The definition of "modification" is being amended by replacing the word "pump" with "diversion" to correct the definition as a pump is not applicable to gravity fed diversions.

"Operating order" is being revised by deleting the reference to a well as the term is meant to be applicable to functioning ground and surface water diversions.

The definition of "unconfined or semi-confined aquifer" is being revised to more accurately characterize an unconfined or semi-confined aquifer.

"Water supply allocation permit" is being amended by adding the phrase "for more than 30 days in a consecutive 365 day period" as diversions which occur for shorter periods of time are proposed to be handled as short term water use permits-by-rule in N.J.A.C. 7:19-2.17(a).

"Water supply critical aquifer" is being amended to be consistent with the 1993 amendments to N.J.S.A. 58:1A-1 et seq.

The definition of "water supply critical area" or "critical area" is being deleted and replaced by "area of critical water supply concern" or "critical area" which is consistent with the 1993 amendments to the Act.

N.J.A.C. 7:19-1.4, Applicability, is being amended to: specify that combined diversions are considered to determine if 100,000 gallons of water per day is being diverted; include water usage certifications in areas of critical water supply concern and in the emergency allocation provisions; delete subsections proposed for recodification elsewhere in these rules; include the emergency allocation provisions; and include temporary dewatering permits, short term water use and dewatering permits-by-rule.

N.J.A.C. 7:19-1.4(a) is being amended to specify that the diversion can be either from a single source or combination of sources, when agricultural or horticultural diversions are subject to regulation in areas of critical water supply concern and under the emergency allocation provisions, when the regulations are applicable to diversions of salt water, and that a person receiving water from a purveyor's water supply system does not need a permit for that water. The Department is also proposing to delete N.J.A.C. 7:19-1.4(a)5 through 7 and incorporate this information dealing with permit modification into the appropriate sections of N.J.A.C. 7:19-1.5. In addition, the Department is proposing to delete N.J.A.C. 7:19-1.4(a)8 as this activity is proposed to be regulated as a permit-by-rule under proposed N.J.A.C. 7:19-2.17(a).

New N.J.A.C. 7:19-1.4(b) is proposed to include those activities previously regulated under N.J.A.C. 7:19A and 7:19B which are being recodified as N.J.A.C. 7:19-9 through 17.

New N.J.A.C. 7:19-1.4(c) is proposed to include temporary dewatering permits as identified at N.J.A.C. 7:19-2.3.

New N.J.A.C. 7:19-1.4(d) is proposed to include short term water use permit-by-rule as identified at N.J.A.C. 7:19-2.17(a).

New N.J.A.C. 7:19-1.4(e) is proposed to include dewatering permit-by-rule as identified at N.J.A.C. 7:19-2.17(b).

N.J.A.C. 7:19-1.5, Major and minor permit modifications, is being proposed to delineate the two categories of permit modifications, major and minor. It identifies what constitutes a major modification and directs the permittee to N.J.A.C. 7:19-2.2 for application requirements. Minor modifications are identified and the procedures to be followed by the permittee seeking a minor modification are set forth.

N.J.A.C. 7:19-1.6, Diversion source categories and requirements, is being added to identify the various categories of diversion sources; the procedures to be followed for maintaining these sources in permits; the criteria for establishing passing flow requirements for diversions from surface sources; and how multiple diversion sources are handled in the permit process.

N.J.A.C. 7:19-1.7, proposed to be recodified from N.J.A.C. 7:19-1.5 and retitled "Unpermitted diversions," is being amended to outline the Department's handling of Water Policy and Supply Council Permits; and how a permittee may utilize non-approved public community water supply sources in a local water emergency.

N.J.A.C. 7:19-1.8, Penalties, proposed to be recodified from N.J.A.C. 7:19-1.6, sets forth that penalties, pursuant to N.J.A.C. 7:19-18, may be assessed for violations of the rules. Amendments reflect that the current subsection (a) is being recodified at proposed N.J.A.C. 7:19-1.7(c) and that the penalty provisions previously at N.J.A.C. 7:14-8 are being recodified at N.J.A.C. 7:19-18.

N.J.A.C. 7:19-1.9, Program information, proposed to be recodified from N.J.A.C. 7:19-1.7, is being amended to reflect the current mailing address for submitting questions on the rules, and to include information regarding the availability of a technical manual for programs administered by the Bureau of Water Allocation and a technical manual for programs administered by the Bureau of Safe Drinking Water.

N.J.A.C. 7:19-1.10, General prohibition, proposed to be recodified from N.J.A.C. 7:19-1.8, ensures proper enforcement authority for viola-

tions of the rules and is being amended to include water use registrations; temporary dewatering permits; the two new categories of permits-by-rule; and water usage certifications.

N.J.A.C. 7:19-1.11, Severability, proposed to be recodified from N.J.A.C. 7:19-1.9, provides that if any part of this chapter is ruled invalid the remainder of the chapter shall be unaffected.

Subchapter 2. Permit and Water Use Registration Procedures; Permits-by-rule

N.J.A.C. 7:19-2.1, Scope, sets forth the scope of the subchapter and is being amended to include temporary dewatering permits, and short term water use and dewatering permits-by-rule. In addition, the Department is proposing to change the name of "Water Use Reports" to "Water Use Registrations."

N.J.A.C. 7:19-2.2, is proposed to be renamed "Application requirements for water supply allocation permits," and is being amended to consolidate various related subsections and reduce duplicative information. This section is being further amended to: specify when hydrogeological reports are required, reduce burdensome application requirements, require submission of the water conservation and drought management plan with the application and identify activities which are exempt from this requirement, and recodify N.J.A.C. 7:19-2.20, Signatories, as N.J.A.C. 7:19-2.2(k).

N.J.A.C. 7:19-2.3 and 2.4 are being proposed for deletion as these additional requirements for public water supplies are no longer used in the permitting process.

N.J.A.C. 7:19-2.3, Application requirements for temporary dewatering permits, is a new section which sets forth the application requirements for temporary dewatering permits.

N.J.A.C. 7:19-2.4, proposed for recodification from N.J.A.C. 7:19-2.5, and renamed "Application requirements for renewal of permits," sets forth the application requirements for renewal of existing permits. This section is being amended to state that permits which are not renewed will expire and all diversion privileges are then terminated, and that an existing permit remains in force until acted upon by the State if the renewal application is filed three months prior to expiration.

N.J.A.C. 7:19-2.5, Application review, proposed for recodification from N.J.A.C. 7:19-2.6, sets forth the application review process to be followed by the Department. This section is being amended to clarify the review process and identify the various deficiencies which would result in the return of an application.

N.J.A.C. 7:19-2.6, Opportunity to review application by interested parties, proposed to be recodified from N.J.A.C. 7:19-2.7, is being amended to indicate that the application can be reviewed after it has been determined to be administratively complete.

N.J.A.C. 7:19-2.7, proposed to be recodified from N.J.A.C. 7:19-2.8, and renamed "Public notice and preliminary decision," sets forth the public notification procedures and preliminary decision process. This section is being amended to clarify both the public notice and preliminary decision processes, by including the individual steps to be taken.

N.J.A.C. 7:19-2.8, The public hearing, proposed to be recodified from N.J.A.C. 7:19-2.10, sets forth the public hearing process which is being amended to clarify the various steps in the hearing process. Additionally, N.J.A.C. 7:19-2.9, Expenses of hearing, is being deleted and the information contained therein has been incorporated into this section.

N.J.A.C. 7:19-2.9, proposed to be recodified from N.J.A.C. 7:19-2.11, and retitled, "Final staff analysis and Hearing Officer's Report," is being amended to include a new subsection dealing with the Department's final staff analysis.

N.J.A.C. 7:19-2.10, Decision making, proposed to be recodified from N.J.A.C. 7:19-2.12, sets forth the decision making process which is being amended to outline each of the steps in the process.

N.J.A.C. 7:19-2.11, Notification of decision, proposed to be recodified from N.J.A.C. 7:19-2.13, sets forth who should be notified of the Department's decision.

N.J.A.C. 7:19-2.12, Record of decision, proposed to be recodified from N.J.A.C. 7:19-14, identifies what information should be contained in the record of decision.

N.J.A.C. 7:19-2.13, proposed to be recodified from N.J.A.C. 7:19-2.15, and renamed "Request for adjudicatory hearing," sets forth the procedure to be followed in appealing the Department's decision. This is being amended to limit third party appeals to those specifically authorized by Federal or State law, pursuant to N.J.S.A. 52:14B-3.1 through 3.3.

N.J.A.C. 7:19-2.14, Permit conditions, proposed to be recodified from N.J.A.C. 7:19-2.16, outlines the permit conditions to be included in water supply allocation permits. This section is being amended to: increase the maximum permit term; identify exemptions to various conditions; include passing flow requirements; and include conditions that are attached to current permits but are not currently identified in this section.

N.J.A.C. 7:19-2.15, Procedures for the recalling of a permit, proposed to be recodified from N.J.A.C. 7:19-2.17, sets forth when and how the Department may recall a permit.

N.J.A.C. 7:19-2.16, Permit cancellation, is a new section which sets forth the steps to be taken by a permittee who wishes to cancel its permit.

N.J.A.C. 7:19-2.17, Short term water use and dewatering permits-by-rule, is a new section which sets forth the requirements for short term water use and dewatering permits-by-rule. Short term water uses were previously handled under a notification process, while the dewatering permit-by-rule is being proposed to reduce the regulatory burden on construction related dewatering activities which would not be expected to have an adverse impact upon the State's water resources.

N.J.A.C. 7:19-2.18 is being retitled "Water use registration requirements." This section is being amended to specify each of the registration submission requirements, and the conditions of a registration.

N.J.A.C. 7:19-2.19, Inactive wells, is being deleted and the information contained in this section is being incorporated into N.J.A.C. 7:19-1.6(a).

N.J.A.C. 7:19-2.20, Signatories, is being deleted and the information contained in this section is being incorporated into N.J.A.C. 7:19-2.2(k).

Subchapter 3. Fee Schedule for Water Supply Allocation Permits and Temporary Dewatering Permits

N.J.A.C. 7:19-3 sets forth the fee schedule for applicants and Water Allocation permittees. Proposed amendments include: incorporation of N.J.A.C. 7:19-3.2, Definitions, into N.J.A.C. 7:19-1.3; identifying when the ground water fee schedule is applicable in N.J.A.C. 7:19-3.5(e); elimination of the refunding of a portion of the application fee for applications which are withdrawn, currently codified in N.J.A.C. 7:19-3.5(g) and (h); providing that application fees over $1,000 may be paid in three equal installments in N.J.A.C. 7:19-3.5(h) pursuant to P.L. 1993, c.361 (N.J.S.A. 13:1D-120 through 124); recodifying N.J.A.C. 7:19-3.6 as N.J.A.C. 7:19-3.7 with the proposed addition of pertinent information with regard to where to send the payment and how to address the check; recodifying N.J.A.C. 7:19-3.7 as N.J.A.C. 7:19-3.8; renumbering the remaining sections accordingly; and proposing a separate, two tier reduced fee schedule in N.J.A.C. 7:19-3.6 for temporary dewatering permits. This is being proposed as the simplified application and review process will require less staff time for administration of this category of permit. The temporary dewatering permit fees were previously considered in the ground water fee schedule.

Subchapter 4. Procedures for Determining, Assessing, and Collecting Payments for Excess Water Diversion

N.J.A.C. 7:19-4 sets forth procedures for establishing and collecting the charges required to be paid by any person diverting water from rivers, streams or lakes with outlets for the purpose of public water supply, or from subsurface, wells or percolating water supplies obtained by exercise of the the State's right of eminent domain. The procedures by which essential data is gathered, by which free allowances are established, and by which additional charges for violating passing flows are determined are described in this subchapter. The subchapter is being proposed for readoption with amendments only to reflect the incorporation of the definitions of N.J.A.C. 7:19-4.3 into N.J.A.C. 7:19-1.3; codification of the remaining sections accordingly; and to add recently established purveyor surface water diversions, to whom these rules are applicable, in N.J.A.C. 7:19-4.6 and 4.8.

Subchapter 5. Small Water Company Takeover Act Regulations

N.J.A.C. 7:19-5 is proposed for readoption without change. This subchapter implements the provisions of N.J.S.A. 58:11-59 et seq., commonly referred to as the Small Water Company Takeover Act, by establishing procedures by which the most suitable public or private entity may acquire a small water company that has not complied with the statutory and regulatory standards concerning actual or imminent public health problems.

Subchapter 6. Water Supply Management Act Rules

N.J.A.C. 7:19-6 contains the administrative mechanisms through which some of the objectives of the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., and more specific goals of the Water Supply Master Plan may be accomplished. The Department is proposing to amend this subchapter by deleting N.J.A.C. 7:19-6.10 through 6.12 which dealt with

water supply critical areas and including applicable portions of these sections in new subchapter N.J.A.C. 7:19-8, Areas of Critical Water Supply Concern. The related definitions from N.J.A.C. 7:19-6.2 are being proposed for incorporation into N.J.A.C. 7:19-1.3, and definitions remaining in the subchapter are being amended to be consistent with the definitions in subchapter 1. Throughout the remaining subchapter wording and format have been modified to improve readability and for consistency with other rules in this chapter.

Subchapter 7. Procedures for Contract Review and Approval

N.J.A.C. 7:19-7 establishes procedures for Departmental approval of contract arrangements between purveyors for the sale and purchase of water. Proposed amendments limit the applicability of N.J.A.C. 7:19-7.2 to bulk sales between purveyors, and the transfer of base allocations and water credits as established in N.J.S.A. 7:19-8. In addition, various sections have been rewritten to clarify the process and the procedures to be followed.

Subchapter 8. Areas of Critical Water Supply Concern

N.J.A.C. 7:19-8 is a new subchapter which sets forth the rules governing the establishment of areas of critical water supply concern. This includes those areas previously established as critical areas, the procedures to be followed in Water Supply Critical Areas I and II, and the procedures to be followed in the transfer of base allocations and water credits. This subchapter is being proposed in order to implement the programs mandated by P.L. 1993, c.202, the recently enacted amendments to the Water Supply Management Act.

N.J.A.C. 7:19-8.1, Scope and authority, sets forth the scope and legal authority for areas of critical water supply concern.

N.J.A.C. 7:19-8.2, Designation of areas of critical water supply concern, sets forth the conditions which must be present in order to designate an area of critical water supply concern.

N.J.A.C. 7:19-8.3, Management of water allocations within areas of critical water supply concern, sets forth the steps to be taken by the Department after the establishment of a critical area, the options available to the Department and affected permittees, and how additional water may be made available.

N.J.A.C. 7:19-8.4, Water Supply Critical Area I, identifies critical area I and the how its base allocations are established.

N.J.A.C. 7:19-8.5, Water Supply Critical Area II, identifies critical area II and incorporates the 1993 amendments to the Act regarding base allocations, water credits, and special considerations.

N.J.A.C. 7:19-8.6, Base allocation transfers, sets forth the conditions under which base allocations may be transferred.

N.J.A.C. 7:19-8.7, Base allocation and water supply allocation credit transfer procedure, sets forth the application procedures, and the criteria under which base allocations and water credits may be transferred.

N.J.A.C. 7:19-8.8, Adjudicatory hearings, sets forth the appeal procedure for the Department's decisions relative to areas of critical water supply concern.

Subchapter 9. Water Supply Emergency Surcharge Schedule Rules

N.J.A.C. 7:19-9 is proposed for readoption and recodification from N.J.A.C. 7:19B and sets forth a water surcharge schedule to govern the retail costs of water supplies during water emergencies declared by the Governor pursuant to N.J.S.A. 58:1A-4. During such an emergency, the Board of Public Utilities will adopt the rates established in these rules to be charged by water purveyors under their jurisdiction. The definition, applicability, and penalty sections have been deleted and transferred to the appropriate sections elsewhere in the chapter. Three technical revisions have been made to make citations and references consistent as recodified.

N.J.A.C. 7:19A is proposed for readoption and recodification, with amendments, as N.J.A.C. 7:19-10 through 17, as follows:

Subchapter 10. Powers of the Commissioner During a State of Water Emergency

N.J.A.C. 7:19-10 is recodified from N.J.A.C. 7:19A-2 and sets forth the restrictions and requirements that the Commissioner may impose on water purveyors and other users during a water emergency. This subchapter is proposed for readoption, as recodified, with one minor technical change to make a cross-reference consistent with the recodification.

Subchapter 11. General Powers of the Department

N.J.A.C. 7:19-11 is recodified from N.J.A.C. 7:19A-3 and sets forth the general requirements that the Commissioner may impose on water users to address or respond to water emergencies. N.J.A.C. 7:19-11.6 outlines the requirements that water purveyors may be ordered to comply with once a drought warning has been identified. This subchapter is proposed for readoption with one technical revision to make a cross-reference consistent with the recodification.

Subchapter 12. Water Emergency Task Force

N.J.A.C. 7:19-12 is recodified from N.J.A.C. 7:19A-4 and establishes the Water Emergency Task Force, identifies the various agencies to be represented, and their role in assisting the Commissioner in the formulation of policy and in rendering decisions. The Department proposes to readopt these rules without change.

Subchapter 13. The Priority based Phased System of Water Restrictions

N.J.A.C. 7:19-13 is recodified from N.J.A.C. 7:19A-5 and sets forth the actions to be taken to manage the State's water supply and the restrictions to be imposed on water users during a water emergency. The phases denoting the severity of the water emergency and the criteria to be considered in determining each phase are also established. N.J.A.C. 7:19-13.1(d) provides that the Department may declare a drought warning prior to an actual water emergency declaration by the Governor. This subchapter is proposed for recodification with technical revisions to include specific examples of adjustable water uses in N.J.A.C. 7:19-13.3.

Subchapter 14. Industrial Curtailment Strategy

N.J.A.C. 7:19-14 is recodified from N.J.A.C. 7:19A-6 and sets forth the components and procedural steps to effectuate this strategy in phases III and IV of a water emergency. It also provides the basis for selective curtailment of water use and requires industrial users to provide water consumption and employment information. This subchapter is proposed for readoption with one technical revision to make a cross-reference consistent with the recodification.

Subchapter 15. Emergency Water Transfer Pricing

N.J.A.C. 7:19-15 is recodified from N.J.A.C. 7:19A-8 and includes the general pricing procedures, and the criteria for pricing transferred water utilized by water purveyors during a declared emergency. These rules are proposed to be readopted without change.

Subchapter 16. Hardship Exemption Procedures

N.J.A.C. 7:19-16 is recodified from N.J.A.C. 7:19A-9 and sets forth the application procedures for exemptions to the adjustable water use bans and water rationing; and the criteria for Departmental review and notification. This subchapter is proposed for recodification with minor technical changes to include a mailing address and to make a cross-reference consistent with the recodification.

Subchapter 17. Department Orders

N.J.A.C. 7:19-17 is recodified from N.J.A.C. 7:19A-10 and sets forth the notice and hearing requirements for Departmental orders issued during a state of water emergency, and the procedures for appealing Departmental orders and Water Emergency Task Force decisions. This subchapter is proposed for recodification with a minor technical change to N.J.A.C. 7:19-17.2 to make the adjudicatory hearing process consistent with this chapter.

Subchapter 18. Civil Administrative Penalties and Requests for Adjudicatory Hearings

N.J.A.C. 7:19-18.1 sets forth the purpose of the subchapter and addresses the Department's authority to seek civil administrative penalties for violations under the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq.

N.J.A.C. 7:19-18.2 describes the Department's process for assessing penalties for violations under the Act. This section also identifies when payment of a penalty is due. In contested cases, payment is due upon the issuance of a final order. In cases where a hearing request is denied by the Department, or when no hearing is requested, a notice of civil administrative penalty assessment (NOCAPA) becomes a final order on the 21st day following receipt of the NOCAPA and payment is due immediately. The Department also proposes factors that may be considered in determining whether and how to settle an administrative penalty.

N.J.A.C. 7:19-18.3 sets forth the procedures for requesting an adjudicatory hearing to contest an administrative order and/or a NOCAPA issued pursuant to the Act.

N.J.A.C. 7:19-18.4 describes the process the Department will use to assess civil administrative penalties for violations of the Act other than refusing to allow lawful entry and inspection (see N.J.A.C. 7:19-18.5) and submitting inaccurate information or a false statement, representation or certification (see N.J.A.C. 7:19-18.6). The Department may assess a civil administrative penalty of up to $1,000 for a first violation, up to $2,500 for a second violation of the same provision, and up to $5,000 for a third and subsequent violations of the same provision.

N.J.A.C. 7:19-18.5 sets forth penalties for refusing to allow lawful entry and inspection under the Act. The Department may assess up to $5,000 against a person who refuses, inhibits or prohibits immediate lawful entry and inspection of any premises, building or place by any authorized Department personnel.

N.J.A.C. 7:19-18.6 sets forth penalties for submitting inaccurate information or a false statement, representation or certification in any application, record, or other document required to be submitted under the Act. The highest penalties, $1,000 to $3,000, are proposed for intentional acts. Moderate penalties, $500.00 to $1,500, are proposed for unintentional but foreseeable acts. Lower penalties, not more than $1,000, are proposed for all other violations under this section. The proposed penalties are consistent with penalties the Department has recently proposed and adopted for similar violations of other environmental laws and regulations. The Department notes that permit applicants may be liable for criminal penalties in connection with the certifications required pursuant to N.J.A.C. 7:19-2.2.

Finally, since the penalty provisions for violations of the Act are being incorporated in N.J.A.C. 7:19-18 as described above, N.J.A.C. 7:14-8.1(a), 8.3(a), 8.4(a), 8.15(a), 8.15(b), 8.15(c), and 8.15(e) are being amended accordingly to delete references to the Act.

Social Impact

New Jersey is an extremely densely populated, diversified state which requires substantial amounts of water. Within the State 750 water supply allocation permits are in effect for those persons diverting over 100,000 gallons of water per day. Without effective planning and management of the quantity and use of the State's water resources, including water supply emergencies, the State's future development and the public health and well-being could be jeopardized. The Department manages the water supplies of the State to protect them for drinking water and for industrial purposes, and to ensure their viability for future generations. Many past water use practices have substantially depleted some water supplies. The proposed readoption of the rules with amendments will enhance the capabilities of the Department and water purveyors to cooperatively manage available water supplies to avert or minimize the severity of critical or potentially catastrophic water shortages.

The Department's proposed new rules concerning the assessment of civil administrative penalties will have a positive social impact by encouraging compliance and discouraging noncompliance with the water supply allocation rules at N.J.A.C. 7:19. Compliance with N.J.A.C. 7:19 will result in the maintenance and conservation of the State's water resources.

The Department has developed one of the most sophisticated and rational water supply management programs in the country. The proposed amendments clarify the rules in order to enable the Department to be more receptive to the needs of the regulated community.

Economic Impact

The permit fees imposed upon the permittees by rules proposed for readoption with amendments are expected to cost the regulated community approximately $2,400,000 annually. Fees for new applications range from $1,325 to $8,085; $615.00 to $4,270 for modifications of existing permits; and $470.00 to $6,695 for annual fees. The fees are based on the allocation amount requested and the type of diversion. The Department is proposing to eliminate the partial refund of application fees for those applications that are withdrawn. The fees assessed will fund 30 positions within the Department and also cover associated program costs. The fee schedule remains unchanged except for the establishment of a separate category for temporary dewatering permits. The Department has reviewed the dewatering program and based upon the nature of this activity, has proposed a two tier rate schedule based on monthly allocation which will result in lower fees for all temporary dewatering permittees. This will reduce revenues by approximately $23,000, which is expected to be offset by the reduction in staff time necessary to administer the dewatering program. The proposed dewatering permit-by-rule for construction related dewatering from confined areas and the simplified temporary dewatering permit process make the reduced fees possible.

In addition to the various fees that are paid by permittees, there are other costs associated with filing for a permit. These costs may include installation of wells in order to conduct a hydrogeologic test; analysis of the hydrogeologic test results; preparation of a map which indicates the location of other nearby diversions, landfills, and contamination sites; and the preparation of a Water Conservation and Drought Management Plan. Generally the services of a professional engineer and/or a hydrogeologist are required to prepare a permit application for a new diversion source or to modify an existing permit, due to the technical nature of these types of applications.

Once a permit is issued, costs to permittees may include reporting of the quantity of water diverted; installation and periodic calibration of totalizing flow meters on diversion sources; testing of water quality for chlorides and sodium; installation of permanent observation wells; and continued monitoring of groundwater levels and/or stream flows.

The costs to permittees for filing of an application and to comply with permit conditions are not expected to increase as a result of the amendments to these rules. In many cases costs will be lowered as a result of simplification of application requirements.

In areas of critical water supply concern, preparation of an Alternative Water Supply Plan and development of an alternative water supply source will be an additional cost to affected permittees.

All water allocation permit holders will be impacted by these fees. However, the fees for the categories of water supply allocation permits other than temporary dewatering permits remain at the level established January 1, 1993. This proposed readoption will not result in any increased financial burden on permittees but will still enable the Department to effectively administer the water supply allocation program.

The proposed amendments will provide a positive economic benefit to the general public, as the implementation of these rules will improve the overall effectiveness of the State's management of its water resources, thus ensuring their viability for future generations. New Jersey's economic growth and welfare depend upon an adequate water supply for potable, industrial and agricultural uses.

The rules proposed for readoption further serve to reduce the overall impact of a drought or other water emergency situation on the economy. They enhance the State's ability to properly manage and conserve water resources and help maintain an adequate water supply for all users, thereby preventing a significant loss of jobs or interruption in the production of goods or in the performance of services. It is anticipated that only in the most advanced phases of a water emergency, should supply and demand management strategies and other conservation efforts prove insufficient, would economic activities be seriously affected by the restrictions mandated under the emergency allocation rules.

The proposed new rules concerning the assessment of civil administrative penalties will have no economic impact on persons complying with the water supply allocation rules. For violators, the economic impact of the rules will vary according to the severity of the violation and the conduct of the violator. The proposed new penalties for submission of inaccurate or false information may decrease the potential civil administrative penalty liability of the violator.

Environmental Impact

Clean and reliable water supplies are essential to the welfare of New Jersey's citizens and businesses. Allowing uncontrolled use of the State's water resources, without regard to long term needs, would ultimately result in an insufficient supply of water as demand grows. The Department's experience shows that pollution threatens significant portions of the water supplies upon which the citizens and businesses of the State depend. Further, during times of drought or other critical water supply situations, the necessity of proper planning and management becomes evident. By planning and properly managing the available water resources, the State's future generations can rely upon having plentiful and clean water to serve their needs.

Readoption of this chapter with the proposed amendments will have a positive effect upon the environment by ensuring the proper management of the water resources of the state for its citizens' future use. This will prevent depletion of water resources, the spread of groundwater contamination and salt water intrusion into aquifers.

Regulatory Flexibility Statement

The rules proposed for readoption apply to all persons having the capability to divert water at a rate of 100,000 gallons per day or greater for public supply and private purposes, to permittees exceeding their passing flow requirements, and small water companies which endanger the public health. Of the approximate 750 permittees and 1100 water use registrants impacted by these rules, the number of "small businesses"

as defined in the Regulatory Flexibility Act, N.J.S.A. 552:14B-16 et seq., will not change. Small businesses diverting water will have to continue to comply with the provisions and requirements of the rules, which may require them to obtain the services of a well driller, certified well sealer, or an engineering or environmental consultant to comply with these rules.

The initial capital cost for each small business that must comply with these rules will be for a water meter and water level indicators. This would add between a few hundred to a few thousand dollars to the initial cost of the diversion source, depending upon the type of device selected. Should the small business divert water in excess of 100,000 gallons per day, it would also incur the costs of applying for a diversion permit, if one has not already been obtained, and the annual permit fee. These fees range from a few thousand to several thousand dollars based upon the size of the diversion.

Subchapters 9 through 17 apply to all businesses which use surface or ground water during a water emergency. The Department estimates that there are approximately 750 facilities in the State potentially subject to the requirements of N.J.A.C. 7:19-9 through 17, each of which is considered to be a "small business" as defined by the the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:1B-16 et seq. To comply with these rules, businesses may be required to submit certain plans or reports depending upon the use of the water, the amount of water utilized, and the source of the water. Small businesses which are water purveyors may be required to develop, submit, update and possibly implement an Emergency Response Plan. During a water emergency, water users with a usage rate of 250,000 gallons or more per day must submit contingency plans, while water purveyors must submit copies of their water surcharge schedules, bi-monthly monitoring reports on rationing programs, and quarterly reports on excess surcharge sums collected.

The costs of compliance with the requirements in N.J.A.C. 7:19-9 through 17 will vary based upon the nature of the facility's water use. However, small businesses which are water purveyors may be reimbursed for reasonable expenses incurred in the implementation of the surcharge schedule. In addition, expenses which are not reimbursed from the Water Emergency Fund can be included in any rate adjustment proceedings before the Board of Public Utilities. This would include expenses incurred as a result of a water emergency.

Small businesses, as defined under the regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., found in violation of N.J.A.C. 7:19 will incur the penalties established under these rules. The information submission requirements and deadline for requesting an adjudicatory hearing to contest a penalty apply to all noticed for violations. Requesters will incur the administrative costs of preparing and submitting the request, and may employ legal representation. Lesser requirements or exceptions based upon business size are not provided since this would undermine the fairness, efficiency and effectiveness of the penalty scheme.

In proposing to readopt this chapter with amendments, the Department has balanced the need to protect and manage the water resources of the State against the economic impact of the rules. Proposed amendments provide for a reduction in temporary dewatering permit fees, simplification of application requirements, and establishment of two no-fee categories of permits-by-rule to ensure protection of the water resources yet reduce the regulatory burden. The Department has determined that to further minimize the impact of the rules would endanger the environment, public health and public safety, and therefore no further exemption from coverage for small businesses is provided.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 7:19-19, 7:19A and 7:19B.

Full text of the proposed amendments and new rules follows (additions indicated in boldface **thus**, deletions indicated in brackets [thus]):

7:14-8.1 Authority and purpose

(a) The purpose of this subchapter is to establish a civil administrative penalty policy governing the uniform assessment of civil administrative penalties. This subchapter shall also govern the Department's assessment of civil administrative penalties for violations of the Water Pollution control Act, N.J.S.A. 58:10A-1 et seq., including violation on any rule or regulation, water quality standard, effluent limitation, administrative order or permit issued pursuant to the Water Pollution Control Act, violation of the rules governing laboratory certification and standards of performance, N.J.A.C. 7:18, and for violations of the Act Concerning Pretreatment of Industrial Wastewater, N.J.S.A. 58:11-64 et seq.,the Water Supply and Wastewater Operators' Licensing Act, N.J.S.A. 58:11-64 et seq., [the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq.], and N.J.S.A.58:10A-21 et seq. (also known as the New Jersey Underground Storage of Hazardous Substances Act). In addition, this subchapter shall govern the Department's administrative assessment of costs pursuant to N.J.S.A. 58:10A-10d(1)(c). This subchapter shall also govern the procedure for requesting an adjudicatory hearing on a notice of civil administrative penalty assessment or an administrative order.

(b)-(e) (No change.)

7:14-8.3 Procedures for assessment, payment and settlement of civil administrative penalties, and affirmative defenses

(a) To assess a civil administrative penalty under the Water Pollution Control Act, the New Jersey Underground Storage of Hazardous Substances Act, **and** the Water Supply and Wastewater Operators' Licensing Act, [and the Water Supply Management Act,] the Department shall notify the violator by certified mail (return receipt requested) or by personal service. This Notice of Civil Administrative Penalty Assessment shall:

1.-4. (No change.)

(b)-(i) (No change.)

7:14-8.4 Procedures to request an adjudicatory hearing to contest an administrative order, a notice of civil administrative penalty assessment or a notice of civil administrative cost assessment; procedures for conducting adjudicatory hearings

(a) To request an adjudicatory hearing to contest an administrative order, a notice of civil administrative penalty assessment, or a notice of civil administrative cost assessment issued pursuant to the Water Pollution Control Act, the New Jersey Underground Storage of Hazardous Substances Act, **or** the Water Supply and Wastewater Operators' Licensing Act, [or the Water Supply Management Act,] the violator shall submit the following information in writing to the Department at Office of Legal Affairs, ATTENTION: Adjudicatory Hearing Requests, Department of Environmental Protection and Energy, CN 402, Trenton, New Jersey 08625-0402:

1.-9. (No change.)

(b)-(c) (No change.)

7:14-8.15 Water Supply and Wastewater Operators' Licensing Act [and Water Supply Management Act] civil administrative penalties

(a) The Department may assess a civil administrative penalty of not more than $5,000 per day for each violation of each provision of the Water Supply and Wastewater Operators' Licensing Act [and the Water Supply Management Act] including, but not limited to, a violation of any rule, license, or administrative order issued pursuant thereto.

(b) The Department shall consider each violation of each provision of the Water Supply and Wastewater Operators' Licensing Act [and the Water Supply Management Act], or any rule, license or administrative order adopted or issued pursuant thereto, as a separate and distinct violation. Each day during which a violation continues shall constitute an additional, separate and distinct offense subjecting the violator to the penalty schedule set forth in (c) below.

(c) The Department shall assess a civil administrative penalty for each violation of each provision of the Water Supply and Wastewater Operators' Licensing Act [and the Water Supply Management Act] and each violation of each provision of any rule, administrative order, permit or license as follows:

1.-3. (No change.)

(d) (No change.)

(e) The Department shall assess a civil administrative penalty against each violator who submits inaccurate information or who makes a false statement, representation or certification in any application, record or other document required to be submitted or maintained under the Water Supply and Wastewater Operators' Licensing Act [or the Water Supply Management Act], or who fails to submit or maintain any application, record, or other document required to be submitted or maintained under the Water Supply and Wastewater Operators' Licensing Act [or the Water Supply Management Act],

or who falsifies, tampers with or renders inaccurate any monitoring device or method required to be maintained by the Water Supply and Wastewater Operators' Licensing Act, **or the Water Supply Management Act**. Each day, from the day of submittal of the false or inaccurate information to the Department to the day of receipt by the Department of a written correction of the inaccurate information or falsified statement, shall constitute an additional, separate and distinct violation. The Department shall determine the amount of the civil administrative penalty based on the conduct of the violator as follows:

1.-3. (No change.)

(f) (No change.)

7:19-1.1 Scope and authority

(a) This chapter shall constitute the Department's rules governing the establishment of privileges to divert water, the management of water quantity and quality, [and] **the** issuance of permits, **and the handling of drought warnings, water emergencies and water quality emergencies considered severe enough to constitute water emergencies** pursuant to **N.J.S.A. 58:1A-1 et seq.,** the Water Supply Management Act[,N.J.S.A. 58:1A-1 et seq.,]; **N.J.S.A. 58:2-1 et seq., commonly known as the Excess Diversion Act; N.J.S.A. 58:12A-1 et seq.,** the Safe Drinking Water Act[, N.J.S.A. 58:12A-1 et seq.,]; **N.J.S.A. 58:11-59 et seq., commonly known as the Small Water Company Takeover Act;** and **N.J.S.A. 58:4A-4.1 et seq., commonly known as** the Subsurface and Percolating Waters Act[, N.J.S.A. 58:4A-4.1 et seq]. This chapter establishes the schedule **and reporting procedures that** persons [diverting] **having the capability to divert** more than 100,000 gallons of water per day shall follow in order to establish their privilege to divert water and obtain a Water Supply Allocation Permit, **a Temporary Dewatering Permit or a Water Use Registration.** [and in] **In** addition, **this chapter** prescribes the application, review, notification and hearing procedures for establishing those privileges.

(b) This chapter also establishes the [reporting] procedures for [persons who have the ability to divert 100,000 gallons of water per day or more from wells but who do not presently do so] **determining, assessing and collecting excess diversion fees; contract review and approval; areas of critical water supply concern; and water emergency allocation.**

7:19-1.2 Construction

(a) This chapter shall be liberally construed to permit the Department to discharge its statutory functions under **N.J.S.A. 58:1A-1 et seq.,** the Water Supply Management Act, [N.J.S.A. 58:1A-1 et seq.]; **N.J.S.A. 58:2-1 et seq., commonly known as the Excess Diversion Act; N.J.S.A. 58:12A-1 et seq., the Safe Drinking Water Act; N.J.S.A. 58:11-59 et seq., commonly known as the Small Water Company Takeover Act; and N.J.S.A. 58:4A-4.1 et seq., commonly known as the Subsurface and Percolating Waters Act.**

(b) (No change)

7:19-1.3 Definitions

The following words and terms, when used in [this chapter] **N.J.A.C. 7:19-1 through 4 and 7 though 17,** shall have the following meanings, unless the context clearly indicates otherwise. **The definitions applicable to N.J.A.C. 7:19-5 and 6 are set forth at N.J.A.C. 7:19-5.2 and 6.2, respectively.**

. . .

"Adjustable water use ban" means the prohibition or restriction of adjustable water uses.

"Adjustable water uses" means those water uses which may be reduced during times of drought warning or water supply emergency. Various examples of adjustable water uses are contained in N.J.A.C. 7:19-13.3.

"Adverse impact upon wells" means an impaired pumping rate or a required change in the construction of a well affected by lowered water levels or any impairment of water quality.

"Annual fee" means a fee charged each calendar year during the period of validity of a permit, regardless if water is diverted from sources included in that permit.

"Applicable water purveyors" means all public-community water systems serving those areas in which Phase II of a water emergency has been initiated.

. . .

"Aquifer" means any subsurface water-saturated zone which is significantly permeable so that it may yield sufficient quantities of water from wells or springs in order to serve as a practical source of water supply.

"Aquifer storage and recovery well" or "ASR well" means a well which is utilized to store potable water in an aquifer during periods of low water demand and then recover the water for potable purposes during periods of high water demand.

"Area of critical water supply concern" or "critical area" means a region of the State where excessive water usage or diversion presents undue stress, or wherein conditions pose a significant threat to the long-term integrity of a water supply source, including a diminution of surface water due to excess groundwater diversion.

"Base allocation" means the permittee's portion of the safe or dependable yield for the affected water resource within an area of critical water supply concern.

"Capability to divert 100,000 gallons of water per day" means having the equipment or diversion structure with the hydraulic capacity to pump or divert 100,000 gallons per day of ground or surface water; for pumping equipment, the hydraulic capacity is equivalent to 70 gallons per minute.

"Certified diversion" means a diversion used for agricultural or horticultural purposes for which a water usage certification has been obtained pursuant to N.J.A.C. 7:20A.

"Chairman" means the Chairman of the Water Emergency Task Force who shall be designated by the Commissioner.

. . .

"Confined aquifer" means an aquifer which contains groundwater under pressure between or below relatively impermeable or significantly less permeable material so that the water surface rises above the top of the aquifer in a well which derives its water from that aquifer.

"Consumptive use" means any use of water diverted from surface or ground waters other than a nonconsumptive use as defined below in this section.

. . .

"Customer of record" means any person, corporation, company, partnership, firm, association, political subdivision of the State, and any state or interstate agency or Federal agency receiving water service from an applicable water purveyor.

. . .

"Dewatering" means the diversion of ground water on a temporary basis from wells, wellpoints, excavations or sumps in order to facilitate construction.

"Diversion source" means the source from which water is diverted.

. . .

"Drought" means a condition of dryness due to lower than normal precipitation, resulting in reduced stream flows, reduced soil moisture and/or a lowering of the potentiometric surface in wells.

"Drought coordinator" means the individual designated by the Commissioner who is responsible for the administration and enforcement of N.J.A.C. 7:19-9 through 17.

"Drought warning" means the status declared by the Department, pursuant to N.J.A.C. 7:19-9.5, where there exists a relative lack of precipitation or a lower than normal storage of water supplies.

"Emergency response plan" means the document submitted by each water purveyor to the Department outlining the actions it will take to assure water supply during a water emergency.

"Emergency well" means a well which is maintained for an unplanned and/or unexpected use, such as fire protection or failure of another well.

"Excess diversion" means the amount of water diverted from streams and lakes with outlets for the purpose of public water supply in excess of the free allowance.

"Excess diversion fee" means the amount charged each person for its annual excess diversion or for the diversion from subsurface, well or percolating water supplies, where the State's right of eminent domain was used to condemn the water supply.

"Facility" means a structure or infrastructure designed and built for a specific purpose.

"Free allowance" means, for the purpose of calculating the excess diversion fee, the amount of water diverted from streams and lakes with outlets for the purpose of public water supply in an amount equal to 100 gallons daily for each inhabitant of the municipality or municipalities supplied, as shown by the census of 1905, or equal to such greater amount being legally diverted on June 17, 1907. Free allowances have been established in N.J.A.C. 7:19-4.8.

"Inactive well" means a well which is not presently being used [and] **but which** is being held in abeyance for future use.

"Industrial users" means those non-residential users excluding multiple dwellings and health care facilities.

"Initial fee" means the fee charged by the Department for the review of an application for a new water supply allocation or temporary dewatering permit.

"Lawful entry" means an entry by the Commissioner into any building, place, or premise pursuant to N.J.S.A. 13:1D-1 et seq. and otherwise provided by law, ordinance, regulation, order, permit, or agreement.

"Local use" means the utilization of the privilege to divert water to supply those areas contained within a purveyor's franchise area, or supply area, as approved by the Department in accordance with this chapter.

"Local water emergency" means there exists or impends, within a purveyor's service area, a water supply shortage and/or water quality emergency which significantly impacts the purveyor's ability to meet water demands.

["Modification" means a change to an existing permit including but not limited to, an increase in allocation, the addition of a new source, an increase in pump capacity of an existing source, the change of use of water or other changes deemed necessary by the Department.]

"Modification fee" means the fee charged by the Department for the review of an application for a major modification of a permit.

"Nonconsumptive use" means the use of water diverted from surface or ground waters in such a manner that it is returned to the surface or ground water at or near the point from which it was taken without substantial diminution in quantity or substantial impairment of quality.

"Non-residential users" means all water users other than residential users.

"Normal water rates" means the prevailing retail rates which were charged by the applicable water purveyors and which were in effect immediately preceding the declaration of a water emergency.

"Operating order" means [a well which is] structurally competent[, with the casing,] **and equipped with a functioning** pump[, piping and wellhouse maintained in such a manner as to not present a threat to the aquifer and/or human health and safety] **or surface water intake.**

"Passing flow requirement" means the volume of water required to be maintained at a selected point in the stream to promote water quality conditions after consideration of the needs of downstream users.

"Permit" means a [Water Supply Allocation Permit] **water supply allocation permit or temporary dewatering permit.**

. . .

"Phase" means the particular level of water emergency severity.

"Phase I" means the first stage of a water emergency during which available water supply levels are determined to be below normal and bans on adjustable water uses may be instituted.

"Phase II" means the second stage of a water emergency during which a more substantial threat to the public health and welfare exists and a specified reduction in water use may be mandated.

"Potentiometric surface" means an imaginary surface which represents the static head of water, relative to sea level, in a well constructed in an aquifer.

. . .

"Purveyor" or "water purveyor" means any person who owns or operates a public water supply.

. . .

"Residential users" means all users of water who reside in a single family home serviced with one meter, or in a multiple unit dwelling with no more than four units serviced with one meter. Where residential and non-residential users are serviced with the same meter, the users shall be classified as non-residential users.

"Safe or dependable yield" or "safe yield" or "dependable yield" means that maintainable yield of water from a surface or ground water source or sources which is available continuously during projected future conditions, including a repetition of the most severe drought of record, without creating undesirable effects, as determined by the Department in accordance with this chapter.

"Saline water" means water containing a chloride concentration in excess of 250 mg/L.

"Salt water" means water containing a chloride concentration in excess of 10,000 mg/L.

"Temporary dewatering permit" means a document issued by the Department to those persons intending to divert, for construction purposes, 100,000 or more gallons of water per day for more than 30 days in a consecutive 365 day period which allows the permittee to temporarily divert water at a rate which may exceed the natural replenishment of the water resource.

"Unconfined or semi-confined aquifer" means an aquifer that is either exposed to atmospheric pressure or bounded by layers of materials which do not serve as an effective barrier to water migration.

"Undiminished return" means, for the purpose of determining fees, the return of diverted surface or ground water to or near the point from which it was taken without substantial diminution in quantity.

"Violator" means any person whom the Department asserts has violated the Act or any rules issued pursuant to the Act.

"Water" **or "waters of the State"** means [any] **all** surface water or ground water in the State.

"Water Conservation and Drought Management Plan" means the plan governing actions to be taken by a permittee under a drought warning or in a water emergency, and the permittee's ongoing effort to conserve water.

"Water emergency" means a declaration by the Governor, upon a finding by the Commissioner, that there exists or impends a water supply shortage and/or water quality emergency of a dimension which significantly impacts water supply and, thereby, endangers the public health, safety or welfare in all or part of the State.

"Water emergency fund" means that repository of all sums collected by the applicable water purveyors pursuant to the water emergency surcharge schedule which are in excess of the amounts which would have been collected under normal water rates.

"Water emergency surcharge schedule" means the rate schedule for the retail costs of water supplies which shall be utilized by applicable water purveyors, as provided by rule, in the event of a water emergency.

"Water Emergency Task Force" or "Task Force" means that State body consisting of inter-agency representatives whose purpose is to assist the Commissioner in the formulation of policy and make recommendations to the Commissioner during a water emergency. The Task Force shall be composed of representatives of the following agencies: the Department of Environmental Protection, the Department of Commerce and Economic Development, the Department of Education, the Department of Labor, the Department of Law and Public Safety, the Department of Community Affairs, the Board of Public Utilities, the Department of Agriculture, the Department of Health, the Department of Treasury, and other agencies as designated by the Commissioner.

"Water resource" means any river, stream, lake, pond, aquifer, other underground source, or other water body which may be diverted.

"Water [Supply Allocation Permit] **supply allocation permit**" means the document issued by the Department to a person granting that person the privilege, so long as the person complies with the conditions of the document, to divert 100,000 or more gallons of water per day **for more than 30 days in a consecutive 365 day period,** for any purpose other than agricultural or horticultural purposes.

"Water [Supply Critical Aquifer] **supply critical aquifer**" means an aquifer within [a water supply critical] **an area of critical water supply concern** where there may be either insufficient water supply, shortage of ground water by overdraft, threat of salt water intrusion or contamination, or where other circumstances exist requiring the Department to impose special water supply management provisions by rule under N.J.A.C. 7:19-[6.10]**8**.

["Water Supply Critical Area" or "critical area" means a water supply area in which it is determined by the Department, after public notice and a public hearing, that adverse conditions exist, related to the ground or surface water, which require special measures in order to achieve the objectives of the Act.]

"Water supply system" means a physical infrastructure operated and maintained to deliver water on either a retail or wholesale basis to customers.

"Water table aquifer" means a geological formation which carries water at atmospheric pressure at the top of the saturated zone.

"Water usage certification" or "certification" means the document issued by a county agricultural agent pursuant to N.J.A.C. 7:20A to a person granting that person the privilege to divert 100,000 gallons or more of water per day from ground and surface water sources for agricultural or horticultural purposes for a five year period.

"Well" means a hole or excavation deeper than it is wide, that is drilled, bored, core driven, jetted, dug or otherwise constructed for the purpose of the removal of, investigation of, or exploration for water.

. . .

"Zone of influence" is the area of ground water which experiences an [effect] **impact** attributable to [the] **a** pumping well.

7:19-1.4 Applicability

(a) This chapter applies to all persons holding existing permits, or diverting, having the [ability] **capability** to divert, or claiming the right to divert more than 100,000 gallons of water per day **either from a single source or a combination of sources,** and to all persons [who in the future wish] **intending** to divert more than 100,000 gallons of water per day except as specified below:

1. **Except for N.J.A.C. 7:19-8, and as noted in N.J.A.C. 7:19-9 through 17** [This] **this** chapter does not apply to diversions for agricultural or horticultural purposes **as defined in N.J.A.C. 7:20A-1.3.**

2. This chapter does not apply to diversions of salt water except where [salt water] **the Department determines that the** diversion and **resultant** usage may affect utilization of fresh water [as determined by the Department].

3. [Permits] **A permit** shall not be required for a person [diverting] **receiving** water from a water purveyor or for transfers of water from a [water purveyor] **permittee** within the scope of an existing permit. [Permit modification shall be required for diversions or transfers of water from permitted usage to another use not within the scope of an existing permit regardless of the same or different ownership of the property.]

4. This chapter does not apply to **persons who make** emergency diversions of water for periods of less than 31 days. An emergency diversion includes the taking of water for the purpose of fire fighting, flood prevention, hazardous substance and/or waste spill response, or **for** other emergency [diversion of water] **purposes** as determined by the Department. In all cases of emergency diversion, the person responsible for the diversion shall contact the Department within 48 hours of initiation of the emergency diversion. If [it is determined that] the emergency diversion is expected to continue for 31 days or more, then [a] **the person initiating the emergency diversion shall apply for a water supply allocation** permit within 30 days after [the beginning of such diversion, in accordance with this chapter] initiating the emergency diversion.

[5. A plant site or group of contiguous properties under common ownership which have a total demand of over 100,000 gallons of water per day may be provided with a water diversion by a single permit.

6. An application for modification of a Water Supply Allocation permit is not required for replacement of an existing well included in an existing water allocation permit. However, prior to the installation of the replacement well, a permittee shall provide the following information to the Department for the new well and the existing well that is to be replaced:

i. The location;

ii. Pump capacity and depth; and

iii. Well permit number and local name or number;

7. A copy of the well abandonment report for the existing well shall be submitted within 30 days of installation of the new well.

8. This chapter does not apply to a diversion of 100,000 gallons of water per day or more for periods of less than 31 days annually. However, the person diverting water shall contact the Department 15 days prior to the initiation of the short term diversion; submit a short term water use report on the forms provided; and repair or replace any well or surface water supply system which becomes damaged, dry, has reduced capacity, reduced water quality, or is otherwise rendered unusable as a result of the diversion.]

(b) N.J.A.C. 7:19-9 applies to applicable water purveyors and their customers during a water emergency. N.J.A.C. 7:19-10 through 17 are applicable to water users during a water emergency and to water purveyors when the Department has identified an area of the State or the entire State as being in a drought warning condition.

(c) A temporary dewatering permit is required for the diversion of 100,000 gallons of water per day or more for more than 30 days in a consecutive 365 day period for construction purposes when the rate of diversion may exceed natural replenishment of the water resource. Temporary dewatering permit application requirements are set forth at N.J.A.C. 7:19-2.3.

(d) A short term water use permit-by-rule is required for the diversion of 100,000 gallons of water per day or more for less than 31 days in a consecutive 365 day period. The requirements for a short term water use permit-by-rule are set forth at N.J.A.C. 7:19-2.17(a).

(e) A dewatering permit-by-rule may be applicable in place of a temporary dewatering permit if any person intends to divert more than 100,000 gallons of water per day for construction related dewatering from coffer dams or a confined area where the impacts of the dewatering are contained. The requirements for a dewatering permit-by-rule are set forth at N.J.A.C. 7:19-2.17(b).

7:19-1.5 Major and minor permit modifications

(a) A major modification of a permit shall be obtained pursuant to N.J.A.C. 7:19-2.2 for the following:

1. A change in water use from that specified in the permit, or permit application, including any increase in the amount of consumptive use of 10 percent or greater.

2. A change in the location of the wastewater discharge of the water withdrawn pursuant to the permit, if the change in location of the wastewater discharge reduces the safe or dependable yield of the water resource or affects downstream permittees.

3. The relocation of an intake or well to a site more than 100 feet from the site specified pursuant to the permit;

4. The addition of a diversion source;

5. An increase in diversion capacity which results in an increased yield from the currently permitted diversion source;

6. An increase in daily or monthly or annual allocation; and/or

7. Any other requested modification to an existing permit condition which has the potential to cause an adverse impact either upon the water resource or upon other users of that resource.

(b) A minor modification of a water supply allocation permit or temporary dewatering permit may be effected pursuant to the following:

1. A permittee shall notify the Department in writing within 30 days of any change in the permittee's name and/or mailing address. The notification shall identify the permittee's current name, permit number, and address.

2. A permittee who enters into an agreement to sell a facility for which a permit has been issued shall notify the purchaser of the facility that the purchaser must obtain prior approval of the transfer of the permit from the Department. The permittee shall provide the Department with written documentation of this notification.

i. The purchaser of the facility shall submit a request for approval of the transfer of the permit in writing to the Department, 30 days prior to the purchase. The request shall include the permit number, the seller's name and mailing address, the effective date of transfer, the purchaser's name and mailing address and telephone number of the person responsible for communicating with the Department regarding the permit, and a statement that the purchaser has reviewed the permit and agrees to comply with its terms.

3. A permittee who installs a replacement well shall notify the Department in writing within 30 days of installation. The notification shall identify the location of the existing and the the replacement well, the pump capacity and depth of the existing and the replacement well, and the well permit number and local name or identifier for the existing and replacement well. The permittee shall submit to the Department a copy of the well abandonment report pursuant to N.J.A.C. 7:9-9.1 for the replaced well within 30 days of placing the replacement well into operation.

4. A permittee seeking a minor modification other than a minor modification specified in (b)1 through 3 above shall submit written information to the Department which demonstrates to the satisfaction of the Department that the proposed modification is not a major modification pursuant to (a)1 through 7 above. The Department will either modify the permit accordingly or notify the permittee that the proposed modification is subject to the requirements of N.J.A.C. 7:19-1.5(a) and 2.2.

7:19-1.6 Diversion source categories and requirements

(a) A permittee with an inactive well who intends to use the well in the future shall request in writing that the Department place the well on inactive status within the scope of the permit and shall:

1. Submit an initial inactive well inspection report on a form provided by the Department;

2. Submit a certification form, provided by the Department, by January 31 of each year thereafter. The permittee shall certify that the well is structurally sound, is protected from vandalism and contamination, and is not a threat to public health. If the permittee operated the inactive well during the year, the total number of hours and gallons pumped shall be reported on the certification form.

3. If the Department determines pursuant to N.J.S.A. 58:4A-4.1 et seq. that the inactive well has not been in operation for three or more years or is improperly maintained so as to pose a threat to the public health or the water resource, the Department will order the permittee to have the well sealed, by a New Jersey licensed well driller who is certified to seal wells, in accordance with N.J.S.A. 58:4A-4.1 et seq. and N.J.A.C. 7:9-9.

(b) A permittee shall maintain each active well in operating order, protect the well from vandalism and contamination, have the well accessible for inspection, operate the well at least once a year and report the amount of water diverted to the Department pursuant to N.J.A.C. 7:19-2.14(a)3. Any well not maintained in accordance with this subsection shall be considered inactive and subject to the requirements in (a) above. Each active well shall be contained within the scope of the permit with an associated allocation.

(c) A permittee shall maintain each emergency well in operating order, protect the well from vandalism and contamination, have the well accessible for inspection, operate the well at least once a year and report the amount of water diverted to the Department pursuant to N.J.A.C. 7:19-2.14(a)3. Each emergency well shall be contained within the scope of the permit but without an associated allocation.

(d) A permittee shall maintain each aquifer storage and recovery well in operating order, protect the well from vandalism and contamination, have the well accessible for inspection, operate the well at least once a year and report the amount of water diverted to the Department pursuant to N.J.A.C. 7:19-2.14(a)3. Each aquifer storage and recovery well is considered an active diversion source and shall be contained within the scope of the permit with an associated allocation.

(e) A permittee shall maintain each inactive, active, or emergency surface water diversion source pursuant to the requirements of (a), (b), or (c) above, as appropriate. The Department will establish a passing flow requirement for each surface water diversion source or ground water diversion that impacts a surface water source as follows:

1. In the case of a diversion source used for public water supply, the Department will establish the passing flow requirement in accordance with the criteria set forth in N.J.A.C. 7:19-4.6(f).

2. In the case of a diversion source used for a purpose other than public water supply, the Department will establish the passing flow requirement at a level that will not reduce the passing flow below the seven day, 10 year low flow as established by the United States Geological Survey.

3. If an applicant proposes a lower passing flow requirement than that established pursuant to (e)1 or 2 above, the applicant shall submit with the permit application, pursuant to N.J.A.C. 7:19-2.2, a detailed environmental impact study which demonstrates to the satisfaction of the Department that no adverse environmental impact will occur as a result of the proposed lower passing flow requirement.

4. The Department will temporarily increase the passing flow requirement established pursuant to (e)1 or 2 above if the Department determines such an increase is warranted to preserve the water quality of the diversion source.

5. The Department will not establish a passing flow requirement for a surface water diversion source if the seven day, 10 year low flow is zero; the stream flow is intermittent; or the size or nature of the watershed is such that a passing flow requirement is impractical.

6. The permittee shall ensure that the intake structure for the surface water diversion source is designed to maintain the passing flow requirement.

(f) A person with multiple diversion sources shall obtain a permit or registration, as applicable, for:

1. A facility or group of contiguous properties under common ownership which have a combined diversion capacity of more than 100,000 gallons of water per day;

2. All diversion sources under common ownership within a single municipality or within an area two miles square which have a combined diversion capacity of more than 100,000 gallons of water per day;

3. Up to 25 wells under common ownership which are part of an interconnected system which lie within an area comprised of a square three miles on each side;

4. Water supply systems which are interconnected, jointly used and jointly operated which have a combined diversion capacity of more than 100,000 gallons of water per day and which meet the criteria of (f)2 and/or 3 above; and

5. If the combined capacity of diversions pursuant to (f)1 through 4 above is less than 100,000 gallons per day the diversions shall be combined with other diversions under common ownership so that the combined diversion capacity is more than 100,000 gallons of water per day.

7:19-[1.5]1.7 [Schedule for applying for Water Supply Allocation Permits] **Unpermitted diversions**

(a) Any person presently diverting or claiming the right to divert more than 100,000 gallons of water per day and who does not hold a valid permit is subject to penalties provided for under N.J.A.C. 7:19-[1.6]**1.8** and shall apply for a permit immediately.

(b) (No change)

(c) Any person who holds a Water Policy and Supply Council permit that was valid prior to February 10, 1982, but who did not reestablish that privilege to divert water as of February 10, 1982, shall apply for a permit immediately in accordance with N.J.A.C. 7:19-2.2.

(d) Any purveyor who, because of a local water emergency, needs to divert water from a diversion source for which the purveyor does not have diversion privileges under a permit pursuant to this chapter shall submit a written request for approval of such diversion to the Administrator of the Water Supply Element, CN-426, Trenton, New Jersey 08625. The purveyor shall be eligible for such an approval only if the following requirements are met:

1. The purveyor and/or the local governing body, as appropriate, shall give public notice a local water emergency exists;

2. The purveyor and/or the local governing body, as appropriate, shall impose mandatory water use restrictions and properly notify its water users;

3. The purveyor shall obtain the certification of a professional engineer or the licensed operator of the public water supply that the water from the unapproved diversion source meets the primary drinking water quality standards of N.J.A.C. 7:10. The certification of the water quality test results shall be submitted to the Department's Bureau of Safe Drinking Water for review and approval;

4. The purveyor shall apply for a major modification of its permit in accordance with N.J.A.C. 7:19-2.2 within 30 calendar days of the initiation of the diversion approved pursuant to this subsection;

5. The purveyor shall apply to the Bureau of Safe Drinking Water for a water works facilities approval in accordance with N.J.A.C. 7:10-11 within 30 calendar days of the initiation of the diversion approved pursuant to this subsection; and

6. The purveyor shall use the diversion approved pursuant to this subsection only on a last on, first off basis until the permit modification pursuant to (d)4 above and water works approval pursuant to (d)5 above are granted.

7:19-[1.6]1.8 Penalties

[(a) Any person presently diverting or claiming the right to divert more than 100,000 gallons of water per day and who does not hold a valid Water Policy and Supply Council permit shall be required to file for a new permit prior to February 10, 1982, and if he fails to apply for a permit or apply to reestablish its privilege to divert water prior to February 10, 1982, his previous right shall no longer be valid.]

[(b)] Failure by any person to comply with any requirement of the Act including, but not limited to, a violation of any rule, license, permit, administrative order or this chapter may result in a penalty in accordance with N.J.A.C. [7:14-8] **7:19-18.**

7:19-[1.7]**1.9** Program information

Unless otherwise specified, any questions concerning the requirements of [this chapter] **N.J.A.C. 7:19-1 through 4 and 7 through 18** shall be directed to the Bureau of Water Allocation, Water Supply Element[, Division of Water Resources], New Jersey Department of Environmental Protection, CN [029] **426**, Trenton, New Jersey 08625. **Questions concerning the requirements of N.J.A.C. 7:19-5 and 6 shall be directed to the Bureau of Safe Drinking Water, Water Supply Element, New Jersey Department of Environmental Protection, CN 426, Trenton, New Jersey 08625. A Technical Manual for each of these programs is available from Maps and Publications, Bureau of Revenue, CN-417, Trenton, New Jersey 08625.**

7:19-[1.8]**1.10** General prohibition

No person shall divert water **either from a single diversion source or from combined diversion sources at a rate in excess of 100,000 gallons of water per day** without obtaining a Water Supply Allocation Permit **or a Temporary Dewatering Permit, a Water Use Registration, or complying with the requirements for a Short Term Water Use Permit-by-Rule or Dewatering Permit-by-Rule** [or filing a water use report] in accordance with this chapter **or a water usage certification in accordance with N.J.A.C. 7:20A.**

7:19-[1.9]**1.11** (No change in text.)

SUBCHAPTER 2. PERMIT **AND WATER USE REGISTRATION** PROCEDURES; **PERMITS-BY-RULE**

7:19-2.1 Scope

[This subchapter prescribes the procedures which shall be followed by applicants and the Department when applying for and processing applications for Water Supply Allocation Permits and water use reports.] **This subchapter prescribes the procedures which shall be followed by applicants when applying for and the Department when processing applications for water supply allocation permits and temporary dewatering permits. This chapter also prescribes the requirements for short term water use and dewatering permits-by-rule and water use registrations.**

7:19-2.2 [General application procedures] **Application requirements for water supply allocation permits**

(a) An applicant for a **water supply allocation** permit **or a major modification of a water supply allocation permit** shall contact the Department in accordance with N.J.A.C. 7:19-[1.7]**1.9** to obtain **current** application forms and other instructions **and information** necessary to file a complete application.

(b) The applicant shall follow all the instructions, complete the application forms, obtain and prepare all other documents required by the instructions, and submit the completed application [and], other [documents] **required information, and any applicable fees required pursuant to N.J.A.C. 7:19-3** to the Department.

(c) The applicant for the diversion of ground water shall [show the classification of land use for all land within half a mile of the proposed diversion point and] provide a discussion of the geology, **hydrogeology, and the expected impacts of the diversion both on the resource and on other users of that resource. An applicant whose application includes a new well, an increase in diversion capacity, and/or an increase in monthly or yearly allocation shall conduct a hydrogeologic test in accordance with New Jersey Geological Survey Geological Survey Report GSR 29, Guidelines for Preparing Hydrogeological Reports for Water-Allocation Permit Applications, with an Appendix on Aquifer-Test Analysis Procedures (GSR 29). These guidelines can be obtained by contacting the Department in accordance with N.J.A.C. 7:19-1.9. The Department shall waive this requirement if sufficient recent hydrogeologic information is obtained by the applicant to allow a comprehensive hydrological evaluation of the impacts of the proposed diversion in accordance with N.J.A.C. 7:19-2.2(d)5. In either case, a final hydrogeologic report completed in accordance with GSR 29 is required to be submitted with the application.**

(d) The applicant for the diversion of surface water shall provide information on the watershed, including:

[1. General land use characteristics;]

[2]**1.** Size of drainage area to the diversion point;

[3]**2.** Stream water quality classification;

[4]**3.** Stream flow records**, including flow duration curves and hydrographs. If there are no stream flow records the applicant shall contact the Department in accordance with N.J.A.C. 7:19-1.9 to determine the procedures to be followed for obtaining stream flow records for a similar stream and adapting those records for use;**

[5]**4.** Upstream and downstream diversions**, and discharges including the volumes and locations thereof, and any information necessary for the applicant to determine impacts**; and

[6. Upstream and downstream wastewater dischargers; and]

[7]**5.** A comprehensive hydrological evaluation of the proposed diversion **and a discussion of the expected impacts of the proposed diversion both on the water resource and on upstream and downstream diversions and discharges.**

(e) The applicant **for the diversion of water** shall provide **a list of the following items, along with** a United States Geological Survey **topographical quadrangle** map with the [following items shown] **locations of the items identified thereon:**

1. All permitted or certified diversions [of greater than 100,000 gallons of water per day,] within a one mile radius**, when diversions from a water table aquifer or a pond fed primarily by ground water are proposed;**

2. All [public water supply sources] **permitted and certified diversions** within a five mile radius **when a diversion from a confined or semi-confined aquifer is proposed;**

3. The proposed withdrawal site**, including latitude and longitude;**

4. All [domestic] **water supply** wells **not listed pursuant to (e)1 and 2 above** [in] **within** the [same or interconnected aquifer within a one mile radius] **zone of influence of the proposed diversion source;**

5. [Landfills] **All landfills** and ground water contamination sites within [a five mile radius] **twice the estimated zone of influence of the proposed diversion up to one mile**; and

6. (No change.)

(f) [In general, an] **An** applicant for a permit shall provide all information which may establish:

1. That the [plans] proposed **diversion** [are] **is** in the public interest[, and provide for the proper and safe construction of all works connected therewith];

[2. That diversion of the quantity of water requested shall not unduly interfere with other existing supplies;]

[3]**2.** That **the** diversion [normally] shall not exceed the natural replenishment or safe yield of the water resources or threaten to exhaust such waters or to render them unfit for use [from any cause];

[4]**3.** That the plans for the proposed diversion are just and equitable to the other water users affected thereby, and that the withdrawal [from the aquifer] does not adversely affect other [permitted] **existing** withdrawals, either ground or surface;

[5. That the proposed diversion will not reduce the dry season flow of any stream so as to adversely affect sanitary conditions, or otherwise unduly injure public or private interests;

6. That, in the case of ground water only, the of the proposed diversion does not lie within a cone of depression where the aquifer to be utilized is overstressed or threatened by saline intrusion; that the location relative to hazardous waste disposal sites or other major source of pollution is not likely to cause or spread ground water contamination and that the diversion will not interfere with any ground water contamination clean-up plans or activity;]

4. That, in the case of a ground water diversion, the proposed diversion will not cause an increase in saline intrusion that renders the water resource unfit for use; will not spread ground water contamination; and will not interfere with any ground water remediation plan or activity;

[7. That there are adequate wastewater facilities for disposal from the areas to be served;]

[8]**5.** If permit application is made for a period [of more] **longer** than [those] **that** listed in N.J.A.C. 7:19-[2.16(a)1]**2.14(a)1**, reasons why a permit of such duration is required by economic considerations, including, for example, necessity of amortizing a new investment over an extended period of time, and the public interest; and

[9. That the zone of influence of any proposed diversion from a water table aquifer does not contain a delineated freshwater wetland. If this is not shown, the applicant shall comply with N.J.S.A. 13:9-1 et seq. and N.J.A.C. 7:7A.]

6. That any structures required for a proposed diversion are not located within a State-designated freshwater wetland or transition area. If this is not shown by submission of a map showing those wetlands or a written statement which identifies those wetland areas, the applicant shall comply with N.J.S.A. 13:9-1 et seq. and N.J.A.C. 7:7A.

[(g) If any of the items in (f) above are not established or there is a more viable alternative source of water available, the application may be denied.]

[(h)](**g**) The applicant shall submit any other information which substantiates the need for the proposed allocation and supports the designated choice of water **resource** for the allocation. For **diversions for** nonpotable purposes the applicant shall analyze the availability and utilization of lower quality water and provide documentation that the diversion is of the lowest acceptable quality **water** considering the intended use. [If it is determined that the applicant can use lower quality water, the permit will be issued only for the use of the lower quality water.]

(h) If the applicant fails to establish any of the items required pursuant to (f) and (g) above, or if the Department determines that a more viable alternative source of water is available, or if the proposed diversion is not in accordance with the New Jersey Statewide Water Supply Plan, the Department will deny the application.

(i) [All plans and specifications submitted with the application shall be signed by, and prepared by or under the supervision of a professional engineer, duly licensed under the laws of New Jersey.] **The applicant shall submit a Water Conservation and Drought Management Plan on forms provided by the Department, unless the diversion for which the applicant seeks a permit will be used for one of the following activities:**

1. Ground water remediation;

2. Sand and gravel mining; or

3. Water which is returned to its source without a substantial diminution in quantity.

(j) The applicant shall submit [information for] **a summary sheet which identifies** all contracts which have been entered into for the bulk sale or purchase of water **in accordance with N.J.A.C. 7:19-7.3**. [Details shall include the effective and expiration dates of the contract and the quantity of water contracted for.]

(k) [All applications shall be signed in accordance with the requirements of N.J.A.C. 7:19-2.20.] **The applicant for a water supply allocation permit shall, upon submission of an initial, renewal or modification application, sign the following certifications on the application forms:**

1. "I certify under penalty of law that the information provided in this document is true, accurate and complete. I am aware that there are significant civil and criminal penalties for submitting false, inaccurate or incomplete information, including fines and or imprisonment." This certification shall be signed by the highest ranking individual at the facility with overall responsibility for that facility.

2. "I certify under penalty of law that I have personally examined and am familiar with the information submitted in this application and all attached documents, and that based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate and complete. I am aware that there are significant civil and criminal penalties for submitting false, inaccurate or incomplete information, including the possibility of fine and/or imprisonment." This certification shall be signed as follows:

i. For a corporation, by a principal executive officer of at least the level of vice president;

ii. For a partnership or sole proprietorship, by a general partner or the proprietor, respectively; or

iii. For a municipality, State, Federal or other public agency, by either the principal executive officer or ranking elected official.

3. Where the highest ranking corporate, partnership, or governmental officer or official at the facility required to certify pursuant to (k)1 above is the same person as the official required to certify pursuant to (k)2, only the certification in (k)1 shall be made. In all other cases, the certifications required pursuant to both (k)1 and 2 shall be made.

(l) The applicant shall submit evidence that the flow meters on all existing diversion sources have been calibrated to within five percent accuracy in the five years prior to the date of application, unless exempted under N.J.A.C. 7:19-2.14(a)4.

[7:19-2.3 Additional application requirements for county or municipal public water supplies

(a) An applicant created pursuant to the Municipal and County Utilities Authorities Law, N.J.S.A. 40:14B-1 et seq., shall submit with its initial application a certified copy of:

1. A resolution duly adopted by a county creating the authority; or

2. An ordinance duly adopted by a municipality creating the authority; or,

3. Parallel ordinances duly adopted by two or more municipalities creating the authority.

7:19-2.4 Additional Water Supply Allocation Permit application requirements for privately owned public water supplies

(a) A privately owned public water supply shall submit with its application;

1. A certified copy of its Certificate of Incorporation as a water company in the State of New Jersey or a Certificate of Good Standing issued by the Secretary of the State of New Jersey listing the charter documents on file and certifying as to the company's present good standing; and

2. A certified copy of the municipal resolution granting consent and franchise or proof of a legislative grant of franchise. For large purveyors where this requirement would be burdensome special arrangements may be made.]

7:19-2.3 Application requirements for temporary dewatering permits

(a) An applicant for a temporary dewatering permit shall contact the Department in accordance with N.J.A.C. 7:19-1.9 to obtain current application forms and other instructions and information necessary to file a complete application.

(b) The applicant shall follow all the instructions, complete the application forms, obtain and prepare all other documents required by the instructions, and submit the completed application, other documents, required information and any applicable fees required pursuant to N.J.A.C. 7:19-3 to the Department.

(c) The applicant shall list the depth to water, the corresponding surface elevations, and the projected depths of excavations and dewatering over the work site.

(d) The applicant shall discuss the geology, hydrogeology, and the expected impacts of the proposed diversion both on the resource and other users of the water resource.

(e) The applicant shall provide a list of the following items, along with a United States Geological Survey topographic quadrangle map with the locations of the items identified thereon:

1. The proposed withdrawal site, including latitude and longitude;

2. All water supply wells within a one-quarter-mile radius; and

3. All landfills and ground water contamination sites within a one-quarter-mile radius.

(f) If dewatering will occur at a depth of greater than 50 feet, the Department may require the applicant to identify the items required pursuant to (e)2 and 3 above at a radius greater than one-quarter-mile.

(g) The applicant shall provide all information which establishes:

1. That the proposed diversion is in the public interest;

2. That the plans for the proposed diversion are just and equitable to the other water users affected thereby, and that the withdrawal does not adversely affect other existing withdrawals, either ground or surface; and

3. That the proposed diversion will not reduce the dry season flow of any river or stream so as to adversely affect the river or stream.

(h) Each applicant for a temporary dewatering permit shall, upon submission of an initial, modification or renewal application sign the certifications on the application forms in accordance with N.J.A.C. 7:19-2.2(k).

7:19-[2.5]**2.4** Application[s] **requirements** for renewal of [existing] permits

(a) Applications for renewal of [existing] **current** permits shall be submitted three months prior to expiration of the current permit.

(b) Applicants for renewal of [existing] **current** permits shall submit appropriate application forms and other information as requested of a specific applicant by the Department for the proper implementation of the Act and this chapter. **Copies of the application forms are included in the 1993 Technical Manual for Water Allocation Permits, prepared by and available from the Department in accordance with P.L. 1991, c.422 (N.J.S.A. 13:1D-111 et seq.), as updated or revised.**

(c) [In a case where] **If** the permittee does not comply with (a) and (b) above, the Department may [take the following action]:

1. (No change.)

2. Take appropriate enforcement action including the assessment of penalties under N.J.A.C. 7:19-[1.6]**18**; and

3. Require the permittee to file an application as a new [permittee] **applicant** in accordance with N.J.A.C. 7:19-2.2[,] **or** 2.3 [and 2.4] and pay the initial [permit] fee and annual [permit] fee as [defined] **set forth** in N.J.A.C. 7:19-3.

(d) **In order to prioritize its workload,** [The] **the** Department[, following receipt of an application for renewal of an existing permit,] may, in its discretion, grant [an] **a one-time** extension of [the] **a** permit for a period not to exceed one year.

(e) A current permit for which a complete renewal application package is submitted to the Department three months prior to the expiration date shall remain in effect until the Department grants or denies the renewal application.

7:19-[2.6]**2.5** [Preliminary application] **Application** review

(a) The Department [shall] **will** make a preliminary review of [the material] **each application** [to determine that the applicant has submitted with its application all documents needed to meet the requirements of N.J.A.C. 7:19-2.2 through 2.5.] **as follows:**

1. If the application does not contain all documents and information required pursuant to N.J.A.C. 7:19-2.2 through 2.4, the Department may, at its discretion, within 20 working days of receipt of the application, return the application or advise the applicant in writing as to the additional information required to make the application administratively complete and the date by which the additional information must be received by the Department. If an application is returned, the applicant will be advised in writing as to the additional information required to make the application complete.

2. If the application contains all documents and information required pursuant to N.J.A.C. 7:19-2.2 through 2.4 and is determined to be administratively complete, the Department, within 20 working days of receipt of the application, will so advise the applicant in writing.

[(b) Upon a determination by the Department that the application is insufficient, incomplete or improperly prepared, the applicant shall be so advised and instructed within 20 working days as to those steps it is required to take to make the application complete.]

(b) The Department will make a technical review of each application within 20 working days after it declares the application administratively complete as follows:

1. If the application does not contain sufficient technical information as required pursuant to N.J.A.C. 7:19-2.2 through 2.4 or if the technical information requires clarification, the Department will so advise the applicant in writing and establish a date by which additional or clarifying information must be received by the Department. If additional or clarifying information is not received by the specified date, the Department may:

i. Return the application; or

ii. Extend the date by which the applicant must provide the additional or clarifying information; or

iii. Deny the application.

(c) The Department will perform a detailed analysis of the technically complete application and will develop a staff recommendation to issue the permit or deny the application. The staff recommendation will include any conditions to be attached to the permit if the recommendation is to issue the permit or an explanation of the reasons for denial if the recommendation is to deny the application.

(d) The Department will issue a permit renewal, with any conditions deemed appropriate by the Department, for the same allocation, except that the Department may, after notice and public hearing, if requested, pursuant to N.J.A.C. 7:19-2.7 through 2.11, reduce the allocation to that quantity currently diverted, subject to contract, or reasonably required for a demonstrated future need.

7:19-[2.7]**2.6** Opportunity to review application by interested parties

Once the Department determines that an application is **administratively** complete in accordance with N.J.A.C. 7:19-[2.6]**2.5(a)**, the application may be reviewed in person at the Department by any interested parties and copies may be obtained from the Department upon payment of the fee for duplication prescribed by law.

7:19-[2.8]**2.7** [Review and] **Public** notice [of hearing requirements] **and preliminary decision**

(a) The Department, following [a] its determination that the application is **technically** complete **pursuant to N.J.A.C. 7:19-2.5(b)**, [shall] **will**:

[1. In the case of renewal applications not involving an increase or decrease in the amount of water diverted, review the material submitted and either issue a new permit containing appropriate conditions, or follow the procedures described in (a)2 below.

2. In all other cases:

i. Set a date for a public hearing on the application if a public hearing is to be held in accordance with N.J.A.C. 7:19-2.10.

ii. Have a notice of hearing published in a newspaper circulating in the territory affected by the application at least 45 days prior to

the scheduled hearing. If the Department determines that an emergency or other similar circumstances require an expedited hearing, the public notice shall be published in a local newspaper at least 14 days prior to the scheduled hearing; and]

1. Publish a notice of application for a water supply allocation permit or temporary dewatering permit in a newspaper of general circulation in the area affected by the proposed diversion. The notice shall contain:

i. A description of the proposed diversion, including but not limited to the source, location, quantity and/or allocation of water to be diverted.

ii. The date of the close of the public comment period on the application, which shall be at least 30 days from the date of publication of the notice of application for a water supply allocation permit, or at least 14 days from the date of publication of the notice of application in the case of a temporary dewatering permit or a local water emergency.

iii. A statement that written comments, arguments or objections to the application may be submitted until the end of the public comment period; and

iv. A statement that a hearing shall be scheduled if any interested party, including the applicant or the Department, so requests in writing, before the end of the comment period. The Department will provide notice of the hearing date in accordance with (d) below; and

[iii]**2.** Notify, in writing, the applicant, the governing bodies of municipalities and counties and water allocation [permit holders] **permittees, certification holders, and water use registrants** within a one mile radius of the diversion and officials of existing public water systems within a five mile radius of the proposed diversion. **If a proposed diversion might impact upstream or downstream diversions, the Department will notify all affected governing bodies and permittees in the watershed that may be affected by the proposed diversion.**

(b) Once the notice of application is published pursuant to (a)1 above, the applicant shall not make any changes to its application, which would be considered a major modification pursuant to N.J.A.C. 7:19-1.5.

[3. The notice shall contain:

i. A description of the application;

ii. A date for the end of the public comment period, which shall last at least 30 days in duration;

iii. A statement that written comments, arguments or objections to the application may be submitted until the end of the public comment period;

iv. A statement that a hearing shall be scheduled if any interested parties, including the applicant and the Department, request that a hearing be held before the end of the comment period. Notice of the hearing date provided in accordance with (a)2 above;

v. If the Department schedules a public hearing, the comment period will be reopened for a period of 30 days during which time the public hearing will be held.

4. If a hearing is held, it shall be before a hearing officer specified by the Department.

(b) Between the time the notice is published and the scheduled date for the hearing, the Department shall review the application and develop staff recommendations concerning the disposition of the application and any conditions that should be included in the permit if issued. These recommendations shall be:

1. Presented at the hearing to be commented upon or objected to; or

2. If there is no hearing, the recommendations shall be submitted to the decision maker for his or her review along with other information prior to making a final determination whether or not to issue the permit and the conditions to be contained therein. Upon written request to the Department, the staff recommendations shall be made available to the applicant or any interested person.]

(c) Between the date of publication of the notice of application and the scheduled date for the close of the public comment period, the Department will review the application and any written comments received. The Department will develop a staff recommendation to either grant or deny the application. The staff recommendation will include any conditions to be attached to the permit if the recommendation is to issue the permit or an explanation of the the reasons for denial if the recommendation is to deny the application. The staff recommendation will be mailed to the applicant to be commented on or objected to approximately 14 days prior to the close of the public comment period, and will be available at the Department for public review during this period.

(d) If the Department does not receive a request for a hearing on the application pursuant to (a) above, the Department will issue a permit or deny the application.

(e) If the Department does receive a request for a hearing on the application pursuant to (a) above, the Department will:

1. Schedule a public hearing, publish a notice of hearing on the application in a newspaper of general circulation in the area affected by the proposed diversion that is the subject of the application at least 30 days prior to the hearing on an application for a water supply allocation permit or 14 days prior to the hearing in the case of an application for a temporary dewatering permit or a local water emergency; and

2. Notify, in writing, the applicant, governing bodies of municipalities and counties and water allocation permittees, certification holders and water use registrants within a one mile radius of the diversion and officials of existing public water systems within a five mile radius of the proposed diversion. If a proposed diversion might impact upstream or downstream diversions, the Department will notify all affected governing bodies and permittees in the watershed.

(f) The notice of hearing in (e) above shall contain:

1. A description of the application;

2. The hearing date and location; and

3. A statement that written comments, arguments or objections to the application may be submitted to the Department until the close of business on the day on which the hearing is held or to the hearing officer at the public hearing.

[7:19-2.9 Expenses of hearing

The cost of advertisement and stenographic record shall be certified to the applicant who shall pay the bill by the specified due date. Payment in full of the bill shall be a condition of the final permit approval.]

7:19-[2.10]**2.8** The public hearing

(a) (No change.)

(b) The Department will designate a hearing officer to preside at the public hearing.

(c) At the public hearing, the Department will present the staff recommendation to issue a permit or deny the application.

Recodify existing (b)-(c) as **(d)-(e)** (No change in text.)

(f) The Department will certify the costs of publication of the notice of application and notice of hearing, and all costs of the stenographic record to the applicant. The applicant shall pay the costs as billed by the Department by the specified due date. Payment in full of these costs shall be a condition of the final permit.

7:19-[2.11]**2.9** [The public hearing report] **Final staff review and Hearing Officer's Report**

(a) The Department will review the hearing transcript in conjunction with the application and written comments timely received and will develop, if necessary, an addendum to the staff recommendation prepared pursuant to N.J.A.C. 7:19-2.7(c). The Department will forward the addendum to the hearing officer.

(b) The hearing officer shall review the application, comments received, [and] the **hearing** transcript, **the staff recommendation, and addendum, if any.** [and] **The hearing officer** shall prepare and submit written findings and recommendations **in the form of a Hearing Officer's Report** to the decision maker for a final decision on the application for a permit.

7:19-[2.12]**2.10** Decision making

[(a) Where no hearing has been held, the decision maker shall review the recommendations of the Department's staff and the

comments received during the public comment period before deciding whether to issue the permit and the accompanying conditions.

(b) Where a hearing has been held the decision maker shall review the hearing report and decide in the Decision Makers Statement whether to issue the permit and the accompanying conditions.]

(a) The decision maker shall review the staff recommendation and addendum, if any, and the Hearing Officer's Report and set forth in the Decision Maker's Statement the decision to issue a permit or deny the application. If the decision is to issue a permit, the Decision Maker's Statement shall include any conditions to be attached to the permit.

[(c)]**(b)** [In addition the] **The** decision maker may review any other documents submitted during the review process and **will** use his **or her** professional judgment when making [his] **a** decision.

[(d)]**(c)** [Permits will] **The permit shall** be issued **or denied** after the **Decision Maker's Statement has been issued and all** applicable fees have been paid.

7:19-[2.13]**2.11** Notification of decision

The applicant shall be notified in writing of the Department's decision **to issue a permit or deny the application**. In addition, all persons who testified at the public hearing, or who provided written comments **or requested notification of the decision on the permit application,** shall be notified by letter of the decision.

7:19-[2.14]**2.12** Record of decision

(a) The Department shall maintain for each application a record that consists of the following:

1. The application documents;
2. Staff recommendation[s] **and addendum, if any;**
3. The [hearing report] **Hearing Officer's Report** and **hearing** transcript;
4. **The Decision Maker's Statement;**
[4]**5.** [Comments] **Written comments** received; **and**
[5]**6.** The permit or letter of denial.

(b) (No change.)

7:19-[2.15]**2.13** [Appeal procedure] **Request for adjudicatory hearing**

(a) An applicant [or any person] who believes himself or herself to be aggrieved, with respect to decisions made by the Department regarding any permit**, permit condition, or application denial** may contest the decision and request a contested case hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the New Jersey Uniform Administrative Procedure Rules N.J.A.C. 1:1, if the Department:

1. (No change.)
2. Revokes, withdraws or modifies a previously issued approval; [or]
3. Denies a contract for the sale of water under N.J.A.C. 7:19-7[.]**; or**
4. **Issues a permit with conditions that the applicant considers unreasonable.**

(b) Requests for a contested case hearing shall be submitted to:

Office of Legal Affairs
ATTENTION: Adjudicatory Hearing Requests
Department of Environmental Protection [and Energy]
CN 402
Trenton, New Jersey 08625-0402

(c)-(d) (No change)

(e) A hearing request not received within 20 days after receipt of the notification by the applicant [or interested party] shall be denied by the Department.

(f) A hearing request based upon a permit condition which was contained in a prior permit held by the applicant and not objected to previously or on an issue not raised by the applicant during the public comment period shall be denied by the Department.

(g) A hearing request based upon a permit condition that the applicant requested in its application shall be denied by the Department.

[(f)]**(h)** If the applicant [or interested party] fails to include all the information required by (d) above, the Department may deny the hearing request.

Recodify existing (g)-(h) as (i)-(j) (No change in text.)

(k) If a permittee pursues a judicial appeal of the Department's final decision on the permit, the permit as issued shall remain in effect pending a decision on said appeal.

7:19-[2.16]**2.14** Permit conditions

(a) Each permit shall contain specific and general conditions including, but not limited to, the following:

1. The term of the permit. The maximum term of a permit shall **not exceed 10 years;** [be based on the size of the diversion as specified under N.J.A.C. 7:19-3.8 (d)

Class	Permit Duration (years)
1	7
2	6
3	5
4	4
5	4
6	4]

2. (No change)
3. That the monthly diversion amount be reported on a quarterly basis **on forms provided by the Department**. The quarters shall end on March 31, June 30, September 30, and December 31. The reports shall be submitted within 30 days after the close of the quarter.
4. That [the] **all** diversion **sources** be [metered] **equipped with totalizing flow meters which shall be calibrated at least every five years** [and evidence of meter calibration shall be provided as required;] **with the following exceptions:**

i. Sources whose sole use is to supply water for purposes of fire protection;

ii. Sand and gravel operations using water for media transport; and

iii. Sources for which the permittee demonstrates that the installation of a totalizing flow meter is impractical or unreasonable;

5. Any permittee with a diversion source that meets the requirements of (a)4i, ii or iii above may estimate the diversion quantity using an accurate and reasonable method approved by the Department. The permittee shall verify the method for accuracy every five years;

[5. Allow the Department, and its representative to:

i. Enter and inspect any site, building or equipment, or any portion thereof, owned or operated by the permittee, at any time, in order to ascertain compliance or non-compliance with N.J.S.A. 58:1A-1 et seq., 58:4A-4.1 et seq., 58:12A-1 et seq., this subchapter, or any other agreement or order issued or entered into pursuant thereto. Such right shall include, but not be limited to, the right to test any equipment at the facility, to sketch or photograph any portion of the site, building or equipment, to copy or photograph any document or records necessary to determine such compliance or non-compliance, and to interview any employees or representatives of the owner, operator or applicant. Such right shall be absolute and shall not be conditioned upon any action by the Department, except the presentation of appropriate credentials as requested and compliance with appropriate standard safety procedures.

ii. Permittees and any employees or representatives thereof, shall assist and shall not hinder or delay the Department and its representatives in the performance of all aspects of any inspection. This assistance includes allowing the Department and its representatives to accompany the person while performing any regulated activity, at a particular building or property for the purpose of inspection of those activities. During such inspection by the Department, the person shall operate equipment under normal routine operating conditions or under such other conditions as may be requested by the Department. The person, shall, upon request, make available such sampling and measurement equipment to the Department for the purpose of making comparative measurements.]

6. Passing flow requirements for surface water sources or ground water sources that influence surface water sources;

7. That the static water levels for ground water sources be determined and reported on the quarterly diversion report pursuant to (a)3 above;

[6]**8.** Allow the transfer of a permit, with the consent of the Department, but only for the identical use of the waters by the transferee; [and]

9. That, in areas of potential for salt water intrusion, a raw water sample be tested for chloride and/or sodium concentration and the result be reported on the quarterly diversion report pursuant to (a)3 above;

10. That the permittee adopt and implement, to the satisfaction of the Department, a Water Conservation and Drought Management Plan. A Water Conservation and Drought Management Plan status report on all measures that have been implemented shall be submitted by the date specified in the permit. Any permittee not required to submit such a plan pursuant to N.J.A.C. 7:19-2.2(i) is exempt from this requirement;

11. That the permittee is responsible for mitigating adverse impacts on ground or surface waters or the users thereof caused as a direct result of their diversion;

[7]**12.** That the Department may modify or revoke the permit, after notice and **after** hearing, **if requested,** for violations of permit conditions, rules adopted or orders issued by the Department, and when deemed necessary for the public interest;

13. That, if the water diverted is used for non-potable purposes, the permittee investigate the feasibility of water reuse;

14. That the water diverted be used for approved purposes;

15. That, if the authorized diversion privileges are not utilized, they shall revert back to the State upon renewal or modification of the permit;

16. That, where a diversion may exceed the natural replenishment, the permittee may be required to install a monitoring well to document the impacts of the diversion upon the aquifer; and

17. That the Department may require a hydrogeologic test if the new diversion causes impacts which contradict the hydrogeologic information submitted with the permit application.

[(b) All permittees shall be required to file a water conservation plan and an annual status report on all conservation measures that have been implemented.]

(b) The permittee shall allow the Department and/or its designated representative to:

1. Enter and inspect any site, building or equipment, or any portion thereof, owned or operated by the permittee, at any time, in order to ascertain compliance or non-compliance with N.J.S.A. 58:1A-1 et seq., 58:4A-4.1 et seq., 58:12A-1 et seq., these rules, or any other agreement or order issued or entered into pursuant thereto. Such right shall include, but not be limited to, the right to require the testing of any equipment at the facility, to sketch or photograph any portion of the site, building or equipment, to copy or photograph any document or records necessary to determine such compliance or non-compliance, and to interview any employees or representatives of the owner, operator or applicant. Such right shall be absolute and shall not be conditioned upon any action by the Department, except the presentation of appropriate credentials as requested and compliance with appropriate standard safety procedures.

2. The permittee, and any employees or representatives thereof, shall assist and shall not hinder or delay the Department and/or its designated representative in the performance of all aspects of any inspection. This assistance includes allowing the Department and/or its designated representative to accompany the permittee while performing any regulated activity at a particular building or property for the purpose of inspection of those activities. During such inspection by the Department and/or its designated representative, the permittee shall operate equipment under normal routine operating conditions or under such other conditions as may be requested by the Department. The permittee shall, upon request, make available such sampling and measurement equipment to the Department as needed for the purpose of making comparative measurements.

(c) The permittee shall protect each diversion source from vandalism, tampering, and contamination at all times. Department approved protection methods include:

1. Locked well/pump house;

2. Location within a locked, secure fenced area;

3. A locked, secure hatch or cover; and/or

4. 24 hour security at the diversion.

7:19-[2.17]**2.15** Procedures for the recalling of a permit **for modification or revocation**

(a) (No change.)

(b) Prior to revoking or modifying the permit, the Department shall provide the permittee with notice and a public hearing, **if requested,** in accordance with **the procedure set forth at** N.J.A.C. 7:19-[2.10]**2.8.**

(c) (No change.)

(d) The [expenses] **costs** of the hearing shall be paid in accordance with N.J.A.C. 7:19-[2.9]**2.8(f).**

[(e) The hearing officer shall issue a public hearing report in accordance with N.J.A.C. 7:19-2.11.]

(e) The hearing officer shall issue a Hearing Officer's Report in accordance with the procedures set forth at N.J.A.C. 7:19-2.9, and the decision maker shall render a decision in accordance with the procedure set forth at N.J.A.C. 7:19-2.10.

(f) The permittee shall be notified of the Department's decision in accordance with **the procedure set forth at** N.J.A.C. 7:19-[2.13] **2.11.**

(g) [The] **A** permittee [or any interested party who would be adversely affected by the Department's decision] **whose permit has been revoked or modified by the Department pursuant to this section** may request [a] **an adjudicatory** hearing in accordance with N.J.A.C. 7:19-[2.15]**2.13.**

7:19-2.16 Permit cancellation

(a) A permittee may request the cancellation of its water supply allocation or temporary dewatering permit as follows:

1. If the permittee's water usage has declined below 100,000 gallons of water per day for more than 30 days in a consecutive 365 day period, the permittee shall submit to the Department a written request for the cancellation of the permit and assignment of a water use registration number in accordance with N.J.A.C. 7:19-2.18.

2. If the permittee does not intend to use a well or wells, the permittee shall submit to the Department a written request for the cancellation of the permit and shall seal any such well in accordance with N.J.A.C. 7:9-9.

3. If the permittee has no current water demand but may use its well in the future, the permittee shall submit to the Department a written request for cancellation of the permit and placement of the well on the Department's list of inactive wells.

7:19-2.17 Short term water use and dewatering permits-by-rule

(a) Any person intending to divert more than 100,000 gallons of water per day for less than 31 days within a consecutive 365 day period may be authorized for such a diversion under a short term water use permit-by-rule, provided such person:

1. Completes and submits a short term water use permit-by-rule notification on a form provided by the Department, at least 30 days prior to the initiation of the diversion. This form is included in the 1993 Technical Manual for Water Allocation Permits, prepared by and available from the Department in accordance with P.L. 1991, c.422 (N.J.S.A. 13:1D-111 et seq.), as updated or revised.

2. Repairs or replaces, as necessary, any well or surface water supply system which is damaged or goes dry, has reduced capacity or reduced water quality, or is otherwise rendered unusable as a result of the diversion authorized pursuant to this subsection; and

3. Submits a short term water use report on a form provided by the Department specifying the amount of water diverted each day during the duration of the diversion authorized pursuant to this subsection.

(b) Any person intending to divert more than 100,000 gallons of water per day for construction related dewatering may be authorized for such diversion under a dewatering permit-by- rule if the diversion is from a coffer dam or a confined area where the impacts of dewatering are contained, provided such person:

1. Submits a letter describing the proposed dewatering, its location, and the dewatering methods to be used to the Department at least 30 days prior to the initiation of the diversion; and

2. Repairs or replaces, as necessary, any well or surface water supply system which is damaged or goes dry, has reduced capacity or reduced water quality, or is otherwise rendered unusable as a result of the diversion authorized pursuant to this subsection.

7:19-2.18 Water use [reporting] **registration** requirements

(a) Any person [having the ability] **who presently has the capability** to divert more than 100,000 gallons of water per day [but not presently doing so shall report] **who diverts less than that quantity and who does not have a current registration, shall immediately register** [their diversion by June 30, 1990] with the Department[,] on [appropriate] forms provided by the Department. **The forms shall be completed in its entirety or the application for registration will be returned so that the applicant can provide any missing information. A site map indicating the location of each diversion source shall also be submitted. Each person who applies for registration shall list in the application the State-assigned well permit numbers pursuant to N.J.S.A. 58:4A-14.** Within [30] **20 working** days following receipt of the [report forms] **application for registration** by the Department, the [applicant shall receive] Department will assign a water use [report] **registration** number.

(b) [All] **Each** person[s] with a water use [report] **registration** [number] shall submit an annual report **by January 31 of each year** detailing **metered** monthly water usage for the [previous] **preceding calendar** year on forms provided by the Department [by January 31 of the following year].

(c) All **diversion** sources [of water] shall be [metered] **equipped with totalizing flow meters, which shall be calibrated at least once every five years,** within 60 days of assignment of a water use [report] **registration** number by the Department or within 60 days of completion of a well, whichever occurs last. **If the diversion source is used solely for the purpose of fire protection or if the registrant demonstrates to the satisfaction of the Department that the installation of a totalizing flow meter is impractical or unreasonable, the registrant may estimate diversion quantities using an accurate and reasonable method approved by the Department.**

[(d) All existing wells described in (a) above shall have all sources metered within 120 days of the effective date of this section.]

[7:19-2.19 Inactive wells

(a) Any person with an inactive well having the capacity to pump more than 100,000 gallons per day who intends to use the well in the future shall inform the Department that the well is to be placed on the Department's inactive well list.

(b) The Department shall maintain a record of these inactive wells.

(c) Each person described in (a) above shall submit an inactive well status report form, provided by the Department, by December 31 of each year. This report shall certify that the well is in operating order and is protected from vandalism and contamination. If the well has pumped during the year, the report shall include the total number of hours and gallons pumped.

(d) If it is determined by the Department that the inactive well will not be used in the future or poses a threat to public health, the well shall be sealed in accordance with N.J.S.A. 58:4A-4.1 et seq. and N.J.A.C. 7:9-9 by a New Jersey licensed well driller who is certified to seal wells.

(e) If the conditions of the inactive well status report form are not met, the Department, in its discretion, may order that the well be sealed.

7:19-2.20 Signatories

(a) All applicants for a water supply allocation permit shall, upon submission of initial or renewal applications, sign the following certification on the application forms:

1. "I certify under penalty of law that the information provided in this document is true, accurate and complete. I am aware that there are significant civil and criminal penalties for submitting false, inaccurate or incomplete information, including fines and or imprisonment."

i. The certification set forth in (a) above shall be signed by the highest ranking individual at the facility with overall responsibility for that facility.

2. "I certify under penalty of law that I have personally examined and am familiar with the information submitted in this application and all attached documents, and that based on my inquiry of those individuals immediately responsible for obtaining the information, I believe that the submitted information is true, accurate and complete. I am aware that there are significant civil and criminal penalties for submitting false, inaccurate or incomplete information, including the possibility of fine and/or imprisonment."

i. The certification required by (a)2 shall be signed as follows:

(1) For a corporation, by a principal executive officer of at least the level of vice president;

(2) For a partnership or sole proprietorship, by a general partner or the proprietor, respectively; or

(3) For a municipality, State, Federal or other public agency, by either the principal executive officer or ranking elected official.

(b) In cases where the highest ranking corporate, partnership, or governmental officer or official at the facility as required in (a)1i above is the same person as the official required to certify in (a)2i, only the certification in (a)1 need be made. In all other cases, the certifications of (a)1 and 2 shall be completed.

(c) All signatures required by this section shall be notarized.]

7:19-3.2 Purpose

The purpose of this subchapter is to establish fees for the water allocation program set forth in N.J.A.C. 7:19-1 and 2 based upon and not to exceed the estimated cost of processing, monitoring, administering and enforcing water supply allocation **and temporary dewatering** permits. The fee schedule shall be annually reviewed with respect to any changes in the costs of processing, monitoring, administering and enforcing water supply allocation **and temporary dewatering** permits. The expenses of public hearings to be charged to applicants by the Department pursuant to N.J.A.C. 7:19-[2.9] **2.8(f)** shall not be included in the calculations of the fee schedule set forth in this subchapter.

[7:19-3.3 Definitions

For the purpose of this subchapter, the following definitions in addition to those found in N.J.A.C. 7:19-1.3 are applicable.

"Annual fee" means a fee charged annually during the period of validity of every permit.

"Dewatering" means the diversion of ground water on a temporary basis from wells or excavations in order to facilitate construction.

"Initial fee" means the fee charged for the review of all applications for new permits.

"Modification fee" means the fee charged for the review of applications for proposed permit modifications.]

Recodify existing 7:19-3.4 and 3.5 as **3.3 and 3.4** (No change in text.)

[7:19-3.6 Payment of annual permit fee

(a) The Department shall submit a bill for next year's annual permit fee to each permittee prior to January 1 of each year.

(b) Each permittee shall remit its annual permit fee for the next fiscal year by August 1 of that year.

7:19-3.7 Failure to submit the annual permit fee payment in a timely manner

(a) Failure to pay the annual permit fee by March 1 of each year shall be considered a violation of the act and subject to the penalty provisions of N.J.A.C. 7:14-8.13 and a voluntary termination and surrender of the permit by the permittee, unless the Department has granted the permittee a written extension of time to pay the fee.

(b) Any permittee who has surrendered his permit in accordance with (a) above and continues to divert water shall be subject to the penalty provisions set forth in N.J.S.A. 58:1A-16 and N.J.A.C. 7:14-8 and will apply for a new permit in accordance with 7:19-2.2.]

7:19-[3.8]**3.5** Fees for Water Allocation Permits

(a) All applicable fees shall be paid in accordance with the fee schedule established in N.J.A.C. 7:19-[3.9]**3.6**. Any person who applies for a new permit or to modify an existing permit shall submit along with the application, the applicable initial or modification fee set forth in N.J.A.C. 7:19-[3.9]**3.6** based on the [size] **class** of the

allocation, listed in (d) below. [If the permit is approved for a smaller class allocation the difference in the initial or modification fee will be refunded.]

(b) Each applicant for a **new permit or a major modification of a** permit shall pay the appropriate annual fee [prior to] **upon** issuance of the permit **or modification** as follows:

1.-4. (No change.)

(c) Any applicant who fails to complete necessary forms, fails to comply with other permit [processing] **application** requirements or who fails to provide information within the time frame(s) established by the Department, shall pay the annual fees which would have been due if the forms, information and [processing] **application** had been completed in a timely manner, except where the Department grants an extension of time prior to an associated due date.

(d) An applicant for a permit shall be placed in the appropriate class below based on the size of the allocation[s] approved in terms of a [monthly] **daily** average**, based upon a 31 day month**:

1.-6. (No change.)

[(e) For the purpose of assessing fees under this subchapter the following shall apply:

1. A plant site or group of contiguous properties under common ownership will be entitled to a single permit.

2. For a water system supplying or servicing a single municipality only, all surface and ground water diversions may be treated as a single permit.

3. For systems supplying or servicing more than a single municipality, each group of surface and ground water diversions and each group of dewatering diversions which either lie within a single municipality or lie within a square of two miles on each side will be treated as a single permit.

4. In the event that grouping of diversions under 2 or 3 above results in a diversion of less than 100,000 gallons per day, the groups shall be combined with other group(s) so that each permitted withdrawal will amount to 100,000 gpd or more.

5. If any ground water diversion is included in a permit, the fee shall be computed using the ground water schedule for the total quantity of withdrawals from all sources.]

(e) For the purpose of assessing fees under this subchapter, if any ground water diversion in excess of 100,000 gallons per day is included in a permit, the fee for the permit shall be computed using the ground water schedule for the total monthly allocation for all sources within the scope of the permit. A diversion from a pond fed primarily by ground water is considered a ground water diversion.

(f) Any hearing [expenses] **costs** shall be paid in full [prior to] **upon** issuance of the permit. If the application has been withdrawn after the public hearing or if the application is denied, the hearing [expenses] **costs** shall be paid by the specified due date of the bill.

(g) If a water supply allocation permit application is withdrawn after the [public notice] **notice of application** has been [given to schedule a public hearing] **published**, the applicant shall be responsible for payment of the cost of **publication of** the [legal advertisement] **notice**. [The applicant shall be refunded 50 percent of the initial or modification fee that was paid when the application was filed.]

[(h) If the water allocation permit application is withdrawn prior to the public notice being given to schedule the public hearing, the applicant will be refunded 75 percent of the initial or modification fee that was paid when the application was filed.]

(h) In accordance with N.J.S.A. 13:1D-120 through 124, an applicant for a new or modified permit for which the application fee exceeds $1,000 may pay such fee in three equal installments. The first installment is due at the time the applicant submits the application for the permit. The second installment is due when the Department notifies the applicant that the permit application is administratively complete. The last installment is due when the Department takes final action on the application.

7:19-[3.9]**3.6** Fee schedule

(a) Fees shall be charged for permits, as applicable, pursuant to the following schedules:

Water Allocation Permit Fee Schedule
[(effective January 1, 1993)]

	Class 1	Class 2	Class 3	Class 4	Class 5	Class 6
1. Initial fees [for new applications]:						
i. Surface water diversions	$2220	$2500	$3225	$5560	$6075	$6590
ii. Ground water diversions	$2780	$3120	$4030	$6950	$7570	$8085
iii. Ground and surface water diversions in which waters are returned undiminished to the source	$1325	$1775	$2220	$2670	$3080	$3495
iv. Dewatering diversions	**$2700**	**$2700**	**$2700**	**$6900**	**$6900**	**$6900**
2. Modification fees:						
i. Surface water diversions	$1030	$1165	$1505	$2595	$3110	$3625
ii. Ground water diversions	$1295	$1455	$1875	$3240	$3755	$4270
iii. Ground and surface water diversions in which waters are returned undiminished to the source	$ 615	$ 825	$1140	$1245	$1345	$1450
iv. Dewatering diversions	**$1200**	**$1200**	**$1200**	**$3200**	**$3200**	**$3200**
3. Annual fees [for permits]:						
i. Surface water diversions	$1070	$1255	$2150	$3705	$4735	$5765
ii. Ground water diversions	$1440	$1665	$2685	$4635	$5665	$6695
iii. Ground and surface water diversions in which waters are returned undiminished to the source	$ 470	$ 770	$1480	$1780	$2080	$2375
iv. Dewatering diversions	**$1400**	**$1400**	**$1400**	**$4600**	**$4600**	**$4600**

7:19-3.7 Payment of annual fee

(a) The Department will send to each permittee an invoice for the next subsequent calendar year's annual fee by December 31 of each calendar year.

(b) Each permittee shall remit the annual fee by March 1 of the calendar year for which the fee is due.

(c) Payments shall be by check or money order made payable to "Treasurer, State of New Jersey," and mailed, with the invoice, by the due date set forth in (a) above to:

Bureau of Revenue
CN 417
Trenton, New Jersey 08625

(d) For each permit issued, the Department will send the permittee an invoice for the applicable annual fee for the remainder of the year in which the permit is issued pursuant to N.J.A.C. 7:19-3.5(b). Payment shall be made by the due date specified in the invoice.

7:19-3.8 Failure to timely submit the annual fee payment

Failure to pay the annual fee by the due date established pursuant to N.J.A.C. 7:19-3.7 shall be considered a violation of the Act subject to the penalty provisions of N.J.A.C. 7:19-18. The Department shall deem such failure to pay the annual fee a voluntary termination and surrender of the permit by the permittee. Any permittee who fails to pay their annual fee by the established due date shall terminate all diversion activity as of the established due date.

SUBCHAPTER 4. PROCEDURES FOR DETERMINING, ASSESSING AND COLLECTING PAYMENTS FOR EXCESS WATER DIVERSION

[7:19-4.3 Definitions

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

"Act" means N.J.S.A. 58:2-1 et seq.

"Commissioner" means the Commissioner of the Department of Environmental Protection or his designated representative.

"Department" means the New Jersey Department of Environmental Protection.

"Divert" or "diversion" means the taking of water from a river, stream, lake, pond, aquifer, well, other underground source, or other waterbody, whether or not the water is returned thereto, consumed, made to flow into another stream or basin, or discharged elsewhere.

"Division" means the Division of Water Resources of the Department of Environmental Protection.

"Excess diversion" means the amount of water diverted from streams and lakes with outlets for the purpose of public water supply in excess of the free allowance.

"Fee" means the amount charged each person for its annual excess diversion or for the diversion of water from subsurface, well or percolating water supplies, where the State's right of eminent domain was used to condemn the water supply.

"Free allowance" means the amount of water diverted from streams and lakes with outlets for the purpose of public water supply in an amount equal to 100 gallons daily for each inhabitant of the municipality or municipalities supplied, as shown by the census of 1905, or equal to such greater amount being legally diverted on June 17, 1907. Free allowances have been established in N.J.A.C. 7:19-4.9.

"Passing flow requirements" means the volume of water required to be maintained at a selected point in the stream to promote water quality conditions after consideration of the needs of downstream users.

"Person" means any individual, corporation, company, partnership, firm, association, owner or operator of a water supply facility, political subdivision of the State and any state.

"Public water supply" means a water supply providing piped water to the public for human consumption.

"Purveyor" means any person operating a public water supply system.

"Water" means any surface or groundwater in the State used for public water supply.]

7:19-[4.4]**4.3** (No change in text.)

7:19-[4.5]**4.4** Diversion reporting requirements

(a) All persons diverting water shall report the quantity diverted each month to the:

[Water Allocation Office
Division of Water Resources
CN 029]
Bureau of Water Allocation
CN 426
Trenton, New Jersey 08625

(b) These reports shall be submitted [on a quarterly basis and are due by:] **in accordance with N.J.A.C. 7:19-2.14(a)3.**

[1. April 15;
2. July 15;
3. October 15; and
4. January 15.]

7:19-[4.6]**4.5** Schedule for calculating and making payment of the amount due pursuant to [the Act] **N.J.S.A. 58:2-1 et seq.**

(a) The Department shall calculate each diverter's excess diversion fee in accordance with the methodology set forth in N.J.A.C. 7:19-[4.7]**4.6** and certify the amount due from each diverter to the State Comptroller of New Jersey each year.

(b) The State Comptroller, through the Bureau of [Collections and Licensing] **Revenue**, shall notify each diverter of the amount it owes the State and the date on which payment is due.

(c) Payments shall be payable to the **Treasurer,** State of New Jersey and mailed by the due date to:

Bureau of [Collections and Licensing] **Revenue**
CN [402] **417**
Trenton, New Jersey 08625

7:19-[4.7]**4.6** Calculation of fees

(a) The Department shall segregate from the quarterly diversion reports those portions of the total diversion from surface water for the purpose of public water supplies subject to the charges authorized by [the Act] **N.J.S.A. 58:2-1 et seq.**

1. The Department shall use the diversion reports of the supplier of water in cases where there is a difference between the supplier's and recipient's report on the quantity of water diverted.

(b) (No change)

(c) The Department shall determine for each [purvey or] **purveyor** the amount of water diverted in excess of the free allowance set forth in N.J.A.C. 7:19-[4.9]**4.8.**

1. (No change.)

(d) (No change.)

(e) The passing flow requirements which apply in these calculations include, but are not limited to, the following:

Purveyor	Gaging Station	Passing Flow (cubic feet per second)
Brick Township M.U.A.	**Metedeconk River near Lakewood**	**13.0**
[Commonwealth Water Company		
Passaic River	Passaic River at Chatham	116
Canoe Brook	Canoe Brook near Summit	2.12
Passaic River at Madisonville	Passaic River near Millington	10.7]
Elizabethtown Water Co.		
Raritan River	Passing flows maintained by N.J. Water Supply Authority	
Hackensack Water Company		
Hackensack River	Hackensack River at New Milford	12.9
Saddle River	Saddle River at Lodi	13.9
Two Bridges	Passaic River	143.3
(except when Passaic Valley Water Commission is diverting at Two Bridges, in which case passing flow will be 27.2 cfs).		
City of Jersey City	To be released from Boonton Dam to the Rockaway River	10.83[1]
[[1]Subject to adjustment when flows in Beaver Brook at the outlet of Split Rock Pond are less than 1.5 cfs.]		
Matchaponix Water Supply Co.	**Matchaponix Brook**	**7.3**
Middlesex Water Co.		
Robinson's Branch of Rahway River	Rahway River at Rahway	4.2
Raritan River	Passing flow maintained by N.J. Water Supply Authority	
New Jersey-American Water Company		
Passaic River	**Passaic River at Chatham**	**116.0**
Canoe Brook	**Canoe Brook near Summit**	**2.12**
Passaic River at Madisonville	**Passaic River near Millington**	**10.7**

[Monmouth Consolidated Water Supply Company]		
Swimming River	Swimming River near Red Bank	9.4
Jumping Brook	Jumping Brook near Neptune	1.16
Shark River	Shark River near Neptune	1.9
Newark Water Dept.	Pequannock River at Macopin	12.3
City of New Brunswick	Lawrence Brook at Westons Mill	8.7
North Jersey District Water Supply Commission	Wanaque River at Wanaque	15.5[1]2
[1Subject to reduction by the amount of flows into reservoir at Awosting less than 4.6 cfs]		
	Ramapo River at Pompton Lakes	61.9
Two Bridges	Passaic River	143.3
(except when Passaic Valley Water Commission is diverting at Two Bridges, in which case passing flow will be 27.2 cfs).		
Passaic Valley Water Commission		
Pompton River	at Pompton Plains	92.8
Passaic River	at Little Falls	89.0
Passaic River	at Two Bridges	27.2
Rahway Water Department		
Rahway River	at Rahway	7.9
Sayreville Borough	**at Duhernal Dam**	**Dec.-April 61.88 May-Nov. 123.78**
City of Trenton		
Delaware River	at Trenton	1,131.1

[1Subject to adjustment when flows in Beaver Brook at the outlet of Split Rock Pond are less than 1.5 cfs.

[2Subject to reduction by the amount of flows into reservoir at Awosting less than 4.6 cfs.

(f) (No change.)

7:19-[4.8]**4.7** (No change in text.)

7:19-[4.9]**4.8** Free allowance determination

(a)-(c) (No change.)

(d) The Department has determined the following free allowances, in accordance with (a) above, for the following purveyors:

Purveyor/Division	Points of Diversion	Free Allowances (million gallons)[3]
Atlantic City Water Dept.	Absecon Creek	1,649.070
Bloomsbury Water Dept.	Musconetcong River	29.200
[Boonton Water Dept.	Stony Brook Reservoir	143.628]
Branchville Water	Dept. Dry Brook	21.571
Brick Township M.U.A.	**Metedeconk River**	**77.453**
[Buckhorn Springs Water Co.	Tributary of Buckhorn Creek	68.219]
Burlington City Water Co.	Delaware River	293.387
Butler Water Co.	Apshawa Brook	139.175
[Commonwealth Water Co.	Canoe Brook/Passaic River	782.889
Commonwealth Water Co.	Madisonville	64.423]
Elizabethtown Water Co.	Millstone River and Raritan River	**1,479.137**
[Including		
Somerville Water Co.		472.067
Highland Park		26.061
Elizabethtown Division		154.395
Plainfield Division		826.614]
City of Elizabeth		2,208.579[1]
Franklin Water Dept.	Franklin Pond	58.400[1]
Hackensack Water Co.	Hackensack River Saddle River Hirschfield Brook Sparkill Brook	9,153.47[2]
Hackettstown M.U.A.	Mine Brook	94.681
Haledon Water Dept.	Oldam Brook	108.551
[High Bridge Water Dept.	Willoughby Brook	50.443]
Jersey City Water Dept.	Rockaway River	16,542.946
Lambertville Water Co.	Tributary of Delaware River	183.084
Matchaponix Water Supply Co.	**Matchaponix Brook**	**0**
[Mendham Water Dept.	India Brook	62.926]
Middlesex Water Co.	Robinson's Branch Rahway River Raritan River	639.006
New Jersey-American Water Company	**Buckhorn Creek Tributary**	**68.219**
	Canoe Brook/Passaic River	**782.889**
	Delaware River	**0**
	Madisonville	**64.423**
	India Brook	**62.926**
[Monmouth Consolidated Water Company]	Swimming River	1,090.946
	Jumping River	16.813
	Shark River	140.615
Southeast Morris County M.U.A.	Harmony Creek	627.253
Newark Water Department	Pequannock River	
Newark and Belleville		13,228.208[1]
Bloomfield		425.882
North Jersey District Water Supply Comm. Including Montclair, Kearny, Glen Ridge, Bayonne and East Newark	Wanaque River Ramapo River Two Bridges	2,825.940
City of Newark		10,340.048
City of New Brunswick New Brunswick and Milltown	Lawrence Brook	957.445
Newton Water Co. Tributary of	Paulinskull River	161.403
[Orange Water Dept.	West Branch [Rockaway River]	952.686]
Passaic Valley Water Commission	Passaic River at Little Falls, or Passaic River at Two Bridges	6,542.7351
[Peapack–Gladstone Water Dept.]	Peapack Brook	58.400]
Rahway Water Dept.	Rahway River	555.397
Salem Water Dept.	Alloway Creek	235.170
Sayreville Borough	**South River**	**174.434**
Sussex Water Dept.	Lake Rutherford	48.107
City of Trenton	Delaware River	4,923.850
United States Army, Fort Dix	**Rancocas Creek**	**0**
Naval Air Propulsion Center	**Delaware River**	**0**

[1Subject to [Allocation] **allocation**.

[2May include credits for releases [to] **from** DeForest Reservoir.

[3For leap year, multiply these quantities by the fraction 366/365.

7:19-[4.10]**4.9** (No change in text.)

7:19-[4.11]**4.10** Appeal procedure

[(a)] Any party aggrieved by the Department's determination of its excess diversion fee may appeal the determination by submitting a letter requesting [a] **an adjudicatory** hearing**, pursuant to N.J.A.C. 7:19-2.13,** to the Department before March 20 or 30 days after receipt of the bill whichever is later.

[(b) For 30 days following receipt of the request for a hearing the Department shall attempt to settle the dispute by conducting such proceedings, meetings and conferences as deemed appropriate.

(c) If such efforts at settlement fail the Department shall file the request for a hearing with the Office of Administrative Law.

(d) The hearing shall be held before an Administrative Law Judge and in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(e) The decision by the Commission, based on the hearing record and the recommendations of the Administrative Law Judge shall be the final administrative decision of the Department.]

7:19-[4.12]**4.11** (No change in text.)

SUBCHAPTER 6. WATER SUPPLY MANAGEMENT ACT RULES

7:19-6.1 Scope and authority

(a)-(d) (No change.)

(e) To avoid the imposition of needless administrative burdens on water purveyors and users, only a limited number of specified requirements in this subchapter apply throughout New Jersey. Other requirements are only applicable within designated [water supply critical] **areas of critical water supply concern,** where special situations require a greater degree of control to be exercised by the Department.

7:19-6.2 Definitions

The following words and terms shall have the following meanings unless the context indicates otherwise:

...

"Adverse impact upon wells" means [a forced reduction in] **an impaired** pumping rate or a required change in the construction of [an affected] **a** well **affected by lowered water levels** or any impairment of water quality.

...

"Aquifer" means any **subsurface** water-saturated zone [in sedimentary or rock stratum] which is significantly permeable so that it may yield sufficient quantities of water from wells or springs in order to serve as a practical source of water supply.

"Area of critical water supply concern" or "critical area" means a region of the State where excessive water usage or diversion presents undue stress, or wherein conditions pose a significant threat to the long-term integrity of a water supply source, including a diminution of surface water supply due to excess groundwater diversion.

...

"Confined aquifer" means an aquifer which contains groundwater confined under pressure between **or below** relatively impermeable or significantly less permeable material so that [its groundwater] the water surface rises above the top of the aquifer **in a well which derives its water from that aquifer.**

...

"Normal demand" means the annual average **daily** demand during the three preceding non-drought years, including normally occurring peaks.

"Purveyor" **or "water purveyor"** means any person who owns or operates a public [community] water [system] **supply.**

...

"Unconfined" or "semi-confined" aquifer" means an aquifer [close to the land surface with continuous] **that is either exposed to atmospheric pressure or bounded by** layers of materials [with permeabilities in the high to low range, extending from the land surface to the base of the aquifer] **which do not serve as an effective barrier to water migration.**

...

["Water supply critical area" or "critical area" means a water supply area in which it is determined by the Department, after public notice and a public hearing, that adverse conditions exist, related to the ground or surface water, which require special measures in order to achieve the objectives of the Act.]

"Water supply system" means a [facility for providing potable] **physical infrastructure operated and maintained to deliver** water **on either a retail or wholesale basis to customers.**

...

7:19-6.3 Determination of safe or dependable yield

(a) [Class 2 and 3 purveyors, within the first year after the effective date of this subchapter, and other purveyors within one year after written request by the Department,] **Each purveyor** shall either accept an estimate of safe yield from surface supplies or of dependable yield of subsurface sources previously made by the Department or submit its own evaluation and estimate for the approval of the Department **within one year after a written request for such an estimate by the Department**.

(b) A purveyor is required to provide a safe or dependable yield of water from its own sources, which, when added to water supplies available by contract and after subtraction of water obliged to be delivered by the purveyor by contract, shall be sufficient to provide for the normal demand of its own customers.

1. (No change.)

2. Water supplies available by contract may be relied upon only if the contract is not subject to cancellation or suspension and [assures the availability of water throughout a period of drought and if the source of supply is reliable] **the safe or dependable yield of the source of supply is not exceeded**. Water obtainable through interconnections shall not be included unless reliable delivery is assured by contract.

3. All contracts relied upon to meet the requirement of this subsection (b) shall be subject to review and approval by the Department, **in accordance with N.J.A.C. 7:19-7,** to determine their compliance with the rules in this Chapter and the Act.

4. (No change.)

(c) If a determination of yield in accordance with (a) above shows that a purveyor has insufficient capacity to meet the normal demands of its customers, the purveyor [may elect to announce its decision to attempt to revise existing contract arrangements by a given date, as necessary, in order to serve the balance of its customers reliably during a drought. In such a case, the purveyor serving the balance of the customers will be required by the Department to immediately obtain a firm yield from some other source] **shall revise existing contract arrangements to reduce system demands, as necessary, or shall immediately obtain additional water supply to increase its safe or dependable yield.**

(d) [As an alternative to] **If the purveyor does not comply with** (c) above, the Department may order a ban on further extensions of service to new customers or expansions of service to existing customers, or the Department may order the acquisition of additional water supply capability, or both. The Department will allow reasonable time for acquisition of additional water supply.

7:19-6.5 Water conservation

(a) Unless more stringent water conservation measures are required by the Department, all public community water systems shall:

1.-2. (No change.)

[3. Submit a water conservation report to the Department on or before the first anniversary of the date on which an allocation permit is granted, or other date specified in the permit. In areas subject to the supervision of the Delaware River Basin Commission, conservation reports shall also be submitted in compliance with Commission requirements. This report must describe the actions taken pursuant to the conservation program and the associated results;]

3. Submit a Water Conservation and Drought Management Plan on forms provided by the Department with each initial, modification, or renewal application for a water supply allocation permit or major modification thereof, or contract approval. The Water Conservation and Drought Management Plan shall include:

i. A description of water conservation components;

ii. Interim, voluntary water use restrictions for implementation during corresponding stages of drought warning, drought emergency, precipitation deficits or reservoir storage deficits;

iii. Voluntary transfers of water via interconnections between water supply systems for use when prescribed reservoir storage level thresholds are reached;

iv. Other measures designed to reduce demand, consumption or water usage or loss, or which otherwise have the effect of maximizing water supplies during periods in which precipitation is lower than average and/or water supply storage is less than normal; and

v. For purveyors with water supply reservoirs, rule curves for reservoirs that can be used to establish storage level thresholds.

4. (No change.)

5. Require installation of water meters for all [new] service connections [and in critical areas, require installation of water meters for all existing service connections]. This shall not apply to fire emergency uses. [Small water] **Water** systems with fewer than 500 service connections **or systems where it is demonstrated to the satisfaction of the Department that metering is not practical** may be exempted from metering if it is shown that the annual average

daily water use by the system does not exceed [350] **75** gallons **per person** per day [per service connection].

[(b) Water systems with less than 500 service connections are not required to comply with the water conservation requirements of (a) 1-4 above until specifically notified by the Department.

1. In critical areas, require installation of water meters for all existing service connections.]

7:19-6.9 Operation of interconnections

(a)-(e) (No change.)

(f) [Higher rates may be charged during an emergency (see the Emergency Water Supply Allocation Plan Regulations, N.J.A.C. 7:19A-8.2).] **Higher rates may be charged during a water emergency pursuant to N.J.A.C. 7:19-15.2.**

(g) (No change.)

[7:19-6.10 Water supply critical areas; general

(a) Water supply critical areas are those areas in which it is determined by the Department, after public notice and a public hearing, that adverse conditions exist, related to the ground or surface water, which require special measures in order to achieve the objectives of the Act. The adverse conditions may include one or more of the following:

1. Shortage of surface water by the diversions from surface or groundwater sources which leave insufficient surface water for authorized users or for environmental protection purposes in an area at least ten square miles in extent.

2. Shortage of ground water by overdraft affecting at least ten square miles of an aquifer, beyond its long-term, dependable yield. This may be demonstrated by a verified mathematical groundwater model. In the event that such model is unavailable, it may be demonstrated by one or more of the following:

i. A progressive lowering of ground water to the extent that existing wells of 50 feet or more in depth are threatened or rendered inoperative;

ii. A reduction of the annual, average potentiometric surface in confined aquifers to at least 30 feet below mean sea level (MSL), a portion of which area is within five miles of salt water or which contains the 250 parts per million or more of chloride isochlor;

iii. A reduction of the annual average potentiometric (pressure) surface in an unconfined or semi-confined aquifer to mean sea level or lower, a portion of which area is either within five miles of salt water or contains the 250 parts per million chloride isochlor;

3. Aquifer pollution, where actual pollution contaminates a substantial part of the aquifer or where major source(s) of hazardous or toxic pollution may be reasonably anticipated to contaminate the aquifer;

4. Location within the Delaware River Basin Commission planning area, where, by interstate agreement, certain reporting, well-drilling, allocation or other requirements apply which are not required elsewhere in New Jersey.

(b) For water supply critical areas described in (a) 1, 2 and 3 above, the delineation shall include all areas adversely affected and a critical area margin, encompassing areas which may be adversely affected if present trends continue. The margin may include, among others, adjacent areas such as where a progressive reduction of the potentiometric surface threatens existing wells or an aquifer with saline contamination or where the slope of the potentiometric surface indicates a major source of water for the overdrawn area. The Department may establish modified restrictions within margin areas from those established for the rest of the critical area.

(c) Within water supply critical areas of the type described in (a)1 and 2 above, where it is necessary to balance competing needs, the Department may require those users to substitute water from a reasonably available alternative source. To the extent practicable, all users shall equitably share the burden of costs of replacement supplies. Procedures set forth in N.J.A.C. 7:19-2 are applicable to reallocations.

(d) Within critical water supply areas of the type described in (a)2 and 3 above, the Department may require the following:

1. Special quality testing;

2. Substitution of alternative sources, as described in (c) above;

3. Artificial recharge, to prolong the life of the aquifer or to mitigate or delay salt water intrusion;

4. Substitution of a different aquifer for the one already in use.

(e) A reduction in withdrawal amount shall not exceed the amount considered necessary to reduce the aggregate withdrawal from the aquifer to the dependable yield from subsurface sources (see N.J.A.C. 7:19-6.2, Definitions).

(f) Within critical water supply areas of the type described in (a) 2, 3 and 4 above, the Department may require water allocation for all wells withdrawing between 10,000 and 100,000 gallons per day, exclusive of single family residences and agricultural and horticultural water use certifications.

(g) In specified portions of water supply critical areas of the types described in (a) 1 and 2 above, where access to an alternative water supply source would be unduly expensive, users may be allowed to withdraw their full allocation from the source in short supply, in accordance with the following:

1. Full allocation is compensated for by corresponding additional reductions on the part of other users; and

2. The Department has given prior approval to the arrangements for full allocations; and

3. The extra costs of the alternative source are or will be equitably distributed between all users within the critical area.

4. Reduction or other restrictions may be arranged through participation in a regional plan approved by the Department.

(h) Within critical water supply areas of the types described in (a) 1, 2 and 3 above, the Department may require additional measures for water conservation, metering and leakage control which are more stringent than those required elsewhere in this chapter.

(i) Within critical water supply areas of the type described in (a) 4 above, the Department may only institute controls and requirements required by interstate mandate unless the same area is also a critical area of the type described in (a) 1, 2 or 3 above. If so classified and mandated, the additional controls and requirements may include water allocation for diversions of less than 100,000 gallons per day, metering, added reporting requirements, restriction of inter-basin diversions, restriction of consumptive uses and water quality testing of wells.

(j) Any area, meeting the criteria of more than one of the critical area types described in (a) above, is subject to the requirements for each applicable type.

(k) Once established, a critical water supply area shall remain a critical area unless modified or designated otherwise by the Department, after determining that the reason(s) for the area's designation as a critical water supply area has changed or ceased to exist.

(l) Within critical areas described in (a)1, 2 and 3 above, the Department may require water allocation for groups of private wells (two or more) associated with a development project where:

1. The total project involves the installation of private, residential water wells, serving more than 30 living units, individually or otherwise; or

2. For nonresidential projects, the total project involves the installation of private wells which will withdraw more than 10,000 gallons per day.

7:19-6.11 Critical water supply areas in other than the coastal plain

(a) The establishment of critical water supply areas in other than coastal plain aquifers will depend upon the geological conditions.

(b) In large areas of fairly uniform characteristics, such as pleistocene buried valley aquifers, criteria may be the same as for coastal zone aquifers.

(c) Where aquifer characteristics are irregular, such as hard rock aquifers and unstratified glacial deposits, such that delineation of lowered piezometric pressure zone is impracticable, only widespread pollution or the existence of general deficiency in water supply without practicable alternative sources, may be bases for establishment of a water supply critical area.

7:19-6.12 Public participation procedures for application of critical area requirements

(a) When the Department determines that a critical water supply area should be established or that arrangements should be initiated

for water allocations other than proportionate to existing allocations with consequent financial adjustments in an established critical area, the following requirements shall be met:

1. A written explanation and request for action shall be sent to parties known to be directly concerned and to concerned municipalities and public interest groups.
2. Public notice shall be given and a public hearing shall be held.
3. Opportunity for written comments shall be given.
4. As appropriate, procedures under N.J.A.C. 7:19-2 shall be followed.

(b) Upon completion of the requirements in (a) above, the Department may issue an administrative order requiring establishment of the arrangements described in (a) above.]

7:19-[6.13]**6.10** Administrative hearings

(a) (No change.)

(b) An adversely affected person may apply in writing to the Department for an administrative hearing before the Office of Administrative Law within 15 days of receiving an order or other final decision pursuant to N.J.A.C. 7:19-6.3(d)[, 6.10(a) and 6.13(b). Requests for administrative hearings relating to critical water supply area determinations under 7:19-6.10(a) shall not stay the effect of such determination nor stay implementation of response measures associated with such determination].

(c) (No change.)

[7:19-6.14 Penalties

Any person that violates any of the provisions of this subchapter shall be subject to the remedies and penalties set forth in section 16 of the Act (N.J.S.A. 58:1A-16).]

SUBCHAPTER 7. PROCEDURES FOR CONTRACT REVIEW AND APPROVAL

7:19-7.1 [Scope] **Purpose and scope**

(a) The purpose of this subchapter is to ensure that the safe yield of a permittee's sources of supply and/or allocations are not exceeded as a result of the permittee's contractual obligations.

(b) This subchapter prescribes the procedures which shall be followed by applicants applying for approval of contracts for the sale of water.

7:19-7.2 Applicability

This subchapter applies to contract arrangements [between purveyors] for the routine sale and purchase of water **to be used by a public water supply or for the transfer of base allocations pursuant to N.J.A.C. 7:19-8.** Contract arrangements for emergency purposes are excluded.

7:19-7.3 Procedures for contract approval

(a) (No change.)

(b) The applicant shall contact the Department in accordance with N.J.A.C. 7:19-1.7 to obtain application forms and other instructions necessary to file a complete application **for contract approval. A complete application shall include:**

1. A copy of the draft contract in final form or the executed contract in the case of existing contracts;

2. A copy of the completed contract review application form. This form is included in the 1993 Technical Manual for Water Allocation Permits prepared by and available (from the Department in accordance with P.L. 1991, c.422 (N.J.S.A. 13:1D-111 et seq.), as updated or revised.

3. A Water Conservation and Drought Management Plan, for each party to the contract, in accordance with N.J.A.C. 7:19- 6.5(a)3, if such plan was not previously filed with the Department.

[(c) The applicant shall follow the instructions to complete the application forms and shall submit the completed application with a copy of the contract to the Department.]

[(d)](c) For new contracts, the contract and application forms shall be filed, **by the party selling the water,** at least two months prior to [the effective date of] **executing** the contract.

[(e) For all contracts which are in force as of the effective date of this subchapter, the applicant shall file an application and copy of the contract with the Department within six months after the effective date of this subchapter.]

(d) For any contract which is in force as of the effective date of this subsection and which has not been approved by the Department pursuant to this subchapter, the party selling water pursuant to the contract shall immediately file an application and a copy of the fully executed contract with the Department.

[(f)](e) The Department, [upon] **within 20 days** of receipt of **a complete application for contract approval will:** [the contract and application forms, shall review the material and determine whether the applicant has sufficient allocation to supply the buyer.]

1. Review the application;

2. Determine whether the applicant has sufficient safe yield and adequate allocation to supply the buyer; and

3. Develop preliminary findings on the potential for the contract to be approved.

(f) The Department will provide a written copy of the preliminary findings to the applicant. The applicant shall review the preliminary findings, verify the information on existing contractual obligations and demands, and submit written comments to the Department within 20 working days from receipt of the Department's preliminary findings.

(g) Within 14 working days of receipt of the applicant's written comments on the Department's preliminary findings the Department will:

1. If the Department determines, pursuant to (e) and (f) above, that an applicant does not have sufficient safe yield and/or allocation to meet its system demands and all contractual obligations, or that the contract is not in accordance with a Department-approved regional plan developed pursuant to N.J.S.A. 58:1A-13, issue a contract denial letter to the applicant.

2. If the applicant and/or the party buying water have not filed and received approval of a Water Conservation and Drought Management Plan pursuant to (b)3 above, issue a contract denial letter to the applicant.

7:19-7.4 Appeal procedure

[The applicant or any interested party who would be adversely affected by the Department's decision may request a hearing in accordance with N.J.A.C. 7:19-2.15.] **An applicant or the party buying water who believes himself or herself aggrieved by a decision of the Department pursuant to this subchapter may request an adjudicatory hearing in accordance with N.J.A.C. 7:19-2.13.**

SUBCHAPTER 8. AREAS OF CRITICAL WATER SUPPLY CONCERN

7:19-8.1 Scope and authority

This subchapter constitutes the rules governing the establishment of and management of water allocations within areas of critical water supply concern pursuant to P.L. 1993, c.202, of the Water Supply Management Act (N.J.S.A. 58:1A-1 et seq.).

7:19-8.2 Designation of areas of critical water supply concern

(a) The Commissioner shall, after notice and public hearing, designate as areas of critical water supply concern those areas in which the Department determines that adverse conditions exist, related to the ground or surface water, such that special measures are required to ensure the integrity and viability of the water supply source and to protect the public health, safety or welfare. The Department shall demonstrate that the designation is warranted through the use of a water supply availability study. The adverse conditions upon which the designation of an area of critical water supply concern is based shall include one or more of the following:

1. Shortage of surface water due to diversions from surface or ground water sources which leave insufficient surface water for permitted, certified, or registered diversions or for environmental protection purposes within a drainage area of at least 10 square miles;

2. Shortage of ground water due to diversions exceeding the long-term, safe or dependable yield of an aquifer in an area of at least ten square miles. The Department may demonstrate such a shortage

by a verified mathematical ground water model, or if such a model is unavailable, by one or more of the following:

i. A progressive lowering of ground water to the extent that existing wells of 50 feet or more in depth are threatened by declining water levels or rendered inoperative;

ii. A reduction of the average potentiometric surface in a confined aquifer such that the 30 foot below mean sea level contour is within five miles of salt water or intersects the 250 part per million chloride isochlor; and/or

iii. A reduction of the average potentiometric surface in an unconfined or semi-confined aquifer to the zero foot contour (mean sea level) or lower, such that the contour line is either within five miles of salt water or intersects the 250 part per million chloride isochlor;

3. Aquifer pollution, such that actual pollution contaminates a substantial part of the aquifer or major sources of hazardous or toxic pollution may be reasonably anticipated to contaminate the aquifer; and/or

4. Location within the Delaware River Basin Commission ground water protection area as designated by the Commission, where it has been determined that adverse conditions exist.

(b) Each area of critical water supply concern designated pursuant to (a)1, 2 or 3 above shall consist of two zones: the depleted zone, which is the area adversely affected, and the threatened zone, which is a margin area, encompassing areas which may be adversely affected if present trends continue. The Department may establish different water use restrictions for the depleted zone and the threatened zone.

(c) Those areas designated by the Department as water supply critical areas prior to the enactment of P.L. 1993, c.202, are deemed areas of critical water supply concern for purposes of this subchapter.

(d) Within areas of critical water supply concern designated pursuant to (a)4 above, the Department may institute controls and requirements only as mandated by interstate agreement unless the critical area is also a critical area designated pursuant to (a)1, 2 or 3 above. Such additional controls and requirements may include metering, additional reporting requirements, restriction of interbasin diversions of water for water supply or wastewater discharge, restriction of consumptive uses and water quality testing of wells.

(e) Upon its determination to designate an area of critical water supply concern, the Department will issue an administrative order establishing the depleted zone and threatened zone boundaries for the area of critical water supply concern.

7:19-8.3 Management of water allocations within areas of critical water supply concern

(a) For each area of critical water supply concern designated pursuant to N.J.A.C.7:19-8.2, the Department, in consultation with affected permittees and local governing bodies, shall:

1. Study water supply availability;

2. Estimate future water supply needs;

3. Identify appropriate and reasonable alternative water supply management strategies, including, but not limited to:

i. Water conservation;

ii. Substitution of alternative water sources;

iii. Participation in a Department approved regional water supply project;

iv. Transfer of diversion rights;

v. Artificial recharge of existing diversion sources; and

vi. Substitution of water supply from a noncritical aquifer; and

4. Select and adopt water supply alternatives after notice and public hearing pursuant to N.J.A.C. 7:19-2.8 through 11.

(b) The Department will issue a Notice of Intent to Modify Permit to each affected permittee, which shall specify the water supply alternatives adopted pursuant to (a) above, each affected permittee's water use as reported pursuant to N.J.A.C. 7:19-2.14(a)3, and the steps each affected permittee shall take to comply with the area of critical water supply concern's management strategies.

(c) The Department will, after notice and public hearing pursuant to N.J.A.C. 7:19-2.8 through 2.11:

1. Modify the conditions of an existing water supply allocation permit or water usage certification in order to limit or reduce the quantity of water which may be diverted to the safe or dependable yield of the water resource, provided any reduction in diversion shall not exceed the amount necessary to reduce the total withdrawal from the aquifer to the dependable yield for the ground water diversion source, as determined by the Department;

2. Allow the permittee to transfer the diversion source location through a permit modification pursuant to N.J.A.C. 7:19-2.2; or

3. Require the permittee to use alternate sources of water.

(d) The Department shall require affected permittees to prepare and submit alternative water supply plans consistent with the alternative water supply management strategies adopted pursuant to (a)4 above. The plan shall identify the permittee's water deficit, the method by which the permittee shall obtain additional water to meet demands, and a schedule for the implementation of the alternative water supply plan.

(e) An affected permittee may only increase its base allocation in accordance with N.J.A.C. 7:19-8.6, and those persons seeking diversion privileges within an area of critical water supply concern shall do so only in accordance with N.J.A.C. 7:19-2.2 and 8.6.

(f) The Department may require, as conditions of water supply allocation permits for diversions in critical areas, measures for water conservation, metering, leak detection and control more stringent than those required as conditions in permits for diversions elsewhere in the State.

(g) Following implementation by affected permittees of the alternative water supply plan adopted pursuant to (d) above, the Department will monitor water levels and water quality within the designated critical areas to determine the effectiveness of the alternative water supply management strategies. If the Department determines that the alternatives implemented are not effective in protecting the water supply source of concern, the Department may revise the designation and impose further restrictions in accordance with this subchapter. The Department will report the results of any monitoring conducted pursuant to this subsection to all affected permittees on an annual basis.

(h) The designation of an area of critical water supply concern shall be modified or rescinded only upon the Department's determination that the adverse conditions on which the designation was based pursuant to N.J.A.C. 7:19-8.2(a) have either worsened, diminished or ceased. The Department will evaluate each critical area designation and the need for any adjustments to the alternative water supply management strategies at intervals of 10 years from the date of implementation of the permittee's alternative water supply plan.

(i) The Department will not issue new or increased diversions from affected aquifers within an area of critical water supply concern except for:

1. Temporary dewatering permits for construction related purposes in accordance with N.J.A.C. 7:19-1.4(c) and 2.3;

2. Ground water remediation in accordance with a Department-approved plan;

3. Transfer of base allocations or water credits in accordance with N.J.A.C. 7:19-8.6;

4. An interim allocation to be utilized by a permittee until an approved alternative water supply is available; and/or

5. Projects that provide recharge of the affected aquifer.

(j) The Department will not issue new or increased diversions from wells located outside the boundaries of an area of critical water supply concern that divert water from an affected aquifer and adversely affect the safe or dependable yield of the aquifer.

(k) The Department may issue an interim allocation pending completion of a Department-approved alternative water supply, if the alternative water supply is not yet available to meet demands. Such interim allocations shall be terminated when the Department approved alternative water supply is available.

7:19-8.4 Water Supply Critical Area I

(a) The Department designated Water Supply Critical Area I by administrative order on July 30, 1985. Based upon regional water supply studies substantiated by United States Geological Survey

monitoring and modeling, and following public notice and public hearings, the Department determined that four aquifers, namely, the Mt. Laurel-Wenonah, the Englishtown, the Old Bridge, and the Farrington aquifers were depleted such that designation as an area of critical water supply concern was warranted. The boundary of the depleted zone of the critical area corresponds to the average potentiometric contour 30 feet below mean sea level for each affected aquifer, as published in "Water Levels in Major Artesian Aquifers of the New Jersey Coastal Plain, 1983 U.S.G.S., WRI 86-4028." The threatened zone, consisting of a three mile wide margin area, surrounds the depleted zone of each aquifer.

(b) The Department will determine base allocations within Water Supply Critical Area I in accordance with the following:

1. The base allocations from the depleted zone of the Mt. Laurel-Wenonah, Englishtown, and Farrington aquifers shall be reduced to an amount equal to $0.50 \times D83$, where D83 is the permittee's 1983 annual withdrawal in millions of gallons from the depleted zone of each of these aquifers, as reported to the Department.

2. The base allocation from the depleted zone of the Old Bridge aquifer shall be reduced to an amount equal to $0.60 \times D83$, where D83 is the permittee's 1983 annual withdrawal in millions of gallons from the depleted zone of the aquifer, as reported to the Department.

3. The base allocation from the threatened zone of the Mt. Laurel-Wenonah, Englishtown, Farrington, and Old Bridge aquifers shall be equal to T83, where T83 is the permittee's 1983 annual withdrawal in millions of gallons from the threatened zone of each of these aquifers, as reported to the Department.

7:19-8.5 Water Supply Critical Area II

(a) The Department designated Water Supply Critical Area II by administrative order on January 15, 1993. Based upon a regional water supply study substantiated by United States Geological Survey monitoring and modeling, and following public notice and public hearings, the Department determined that the Potomac-Raritan-Magothy (PRM) aquifer system was depleted such that designation as an area of critical water supply concern was warranted. The boundary of the depleted zone of the critical area corresponds to the average potentiometric contour 30 feet below sea level for the PRM, as published in "Water Levels in Major Artesian Aquifers of the New Jersey Coastal Plain, 1983 U.S.G.S., WRI 86-4028." The threatened zone surrounds the depleted zone of the critical area.

(b) The Department will determine base allocations within Water Supply Critical Area II in accordance the following:

1. For those allocations existing on July 24, 1993 for a period of not less than 10 years from that date, the Department shall not reduce any existing allocation to an amount less than either the amount withdrawn from the depleted and/or threatened zone in 1991 or the amount determined pursuant to (b)1i or ii below, whichever is smaller.

i. The base allocation from the depleted zone shall be:

$$DZ = (0.65 \times D83) + (Dmax - D83)$$

Where DZ equals the depleted zone base allocation in millions of gallons per year (MGY); D83 is the permittee's 1983 annual withdrawal from the depleted zone of the Potomac-Raritan-Magothy (PRM) aquifer system in MGY; and Dmax is the permittee's maximum annual withdrawal in MGY from the depleted zone of the PRM aquifer system between 1983 and 1991.

ii. The base allocation from the threatened zone shall be the maximum annual withdrawal in millions of gallons per year from the threatened zone of the PRM aquifer system between 1983 and 1991.

2. The base allocation for each affected permittee with multiple, interconnected permits shall be determined using the single year in which the annual withdrawal from all diversion sources in the PRM aquifer system was greatest.

3. The base allocation for each affected permittee with diversion sources in both the depleted and the threatened zone of the PRM aquifer system shall be determined using the single year with the largest combined withdrawals from the depleted and threatened zones.

(c) Where an affected industrial permittee demonstrates to the satisfaction of the Department that its withdrawals from the PRM aquifer system were less in 1991 than in any year between 1983 and 1990 due to economic conditions, the industrial permittee's base allocation shall be determined according to (b)1i and/or ii above and shall not be limited to the amount withdrawn in 1991.

(d) The area north of Rancocas Creek from its confluence with the Delaware River to the intersection of the southwest branch of the Rancocas Creek with State Route 38, then north of State Route 38 to the start of County Route 530, then north of County Route 530 to the intersection of County Route 530 with State Route 70 to the Burlington-Ocean county boundary is designated the Water Allocation Credit Receiving Area for Water Supply Critical Area II. Within this Water Allocation Credit Receiving Area, the following shall apply:

1. The allocation represented by one-half of the difference between the total base allocation as established pursuant to (b) above for all permittees and the total of 1991 withdrawals from the PRM aquifer system is designated water allocation credits.

2. Such water allocation credits may be transferred provided that the credits transferred are for local use only, as "local use" is defined in N.J.A.C. 7:19-1.3, and the increased diversion will not have an adverse impact upon the PRM aquifer system or other users of the system. The transfer shall be made in accordance with N.J.A.C. 7:19-8.7.

3. The base allocation of any affected permittee in the Water Allocation Credit Receiving Area who demonstrates that a net reduction in its water use over the period from 1978 to 1991, inclusive, was the result of documented water conservation efforts shall be supplemented by water conservation credits. Water conservation credits shall be equal to 50 percent of the difference between the maximum volume of water withdrawn during this period and 1991, and shall be used by the permittee to satisfy its water demands. Conservation credits cannot be sold, leased or transferred from their geographic location.

4. A supplier of an interconnected system shall have the right to obtain water allocation credits in an amount that would allow transfer of additional volumes through the interconnection provided that the additional volumes of water transferred are for local use only, as "local use" is defined in N.J.A.C. 7:19-1.3, and that such additional volumes do not exceed 50 percent of the volume transferred through the interconnection in 1991.

(e) The governing body of a county may establish a water allocation credit exchange. The water allocation credit exchange shall initially contain the water allocation credits determined pursuant to (d)1 above. The water allocation credits shall be considered a common resource, administered by the county in consultation with the Department. Any county governing body that establishes a water allocation credit exchange shall submit to the Department an implementation plan for review and approval.

(f) Water allocation credits become part of a permittee's base allocation once they are transferred from the water allocation credit exchange to the permittee. Transfers of water allocation credits from the credit exchange are subject to Department approval in accordance with N.J.A.C. 7:19-8.7.

7:19-8.6 Base allocation transfers

(a) Within areas of critical water supply concern, a permittee may transfer base allocations with the Department's approval, in order to facilitate the transfer of water to areas of anticipated growth and areas where alternative supplies of water are not available.

(b) The base allocation from the sending party, the permittee from which the base allocation is transferred, shall be transferred to the receiving party, the permittee to which the base allocation is transferred. Upon transfer of all or a portion of the base allocation by the sending party, the diversion privileges for that permittee shall be reduced by the Department, by an amount equal to the transferred base allocation and the diversion privileges of the receiving party shall be increased by an amount equal to the transferred base allocation.

(c) A permittee proposing to permanently transfer a portion of its base allocation to another permittee may do so either in a direct transaction between the two parties or through the auspices of a county water credit exchange established pursuant to N.J.A.C.

7:19-8.5(e). The Department shall review and approve such a permanent transfer in accordance with N.J.A.C. 7:19-8.7.

(d) The Department does not consider the leasing of base allocations a viable long term water supply alternative but may consider it to be an interim measure.

(e) The permittee proposing to transfer all or part of its base allocation diversion privileges must be the applicant for approval of the transfer of base allocation pursuant to N.J.A.C. 7:19-8.7.

7:19-8.7 Base allocation and water supply allocation credit transfer procedure

(a) A permittee seeking to transfer all or part of its base allocation or the permittee seeking to obtain water supply allocation credits shall submit an application to the Department which shall include the following:

1. A map showing the locations of the wells from which the base allocation is proposed to be transferred and the location of the receiving wells. Wells shall be identified by the Department's well permit number;

2. The aquifer and amount of base allocation or water supply allocation credits to be transferred;

3. An assessment of the impact of the transfer on the water resource and other users of the resource in the vicinity of receiving wells; and

4. Information demonstrating that the sending party's demands can be met after the transfer of the base allocation.

(b) The Department shall approve, subject to other applicable requirements of this chapter, a permanent transfer of any or all of a permittee's base allocation to another permittee through a permit modification in accordance with N.J.A.C. 7:19-2.2, provided that the transfer will not result in:

1. A diversion which is from an aquifer different from that in which the sending well is located;

2. A diversion which is closer to the salt water interface;

3. A diversion which is in a portion of the aquifer which has a lower potentiometric surface than the sending well;

4. A diversion which further degrades the condition of the water supply source; and

5. The sending party's inability to meet its water supply demands.

(c) The Department will not approve a transfer of base allocations or water allocation credits if the receiving party does not develop and implement an appropriate water conservation and drought management plan pursuant to N.J.A.C. 7:19-2.14(a)10 or if the alternative water supply plan required pursuant to N.J.A.C. 7:19-8.3(d) is not in accordance with the water supply alternatives adopted by the Department pursuant to N.J.A.C. 7:19-8.3(a)4.

(d) The receiving party's use of the water does not have to be for the same purpose as the sending party's use of the water.

(e) Any wells for which the total diversion privileges have been transferred shall be sealed in accordance with N.J.A.C. 7:9-9.

(f) If, because of the receipt of the transferred base allocation or water supply allocation credits, the receiving party would require a new diversion source, an increase in pumping capacity, or an increase in monthly and/or yearly allocation, the receiving party shall apply for a permit modification in accordance with N.J.A.C. 7:19-2.2.

(g) If the purchase of additional base allocation or water supply allocation credits is solely for the purpose of replacing water allocation reduced as a result of Department-implemented action, this will be considered a minor modification of the permit. Upon receipt of notification that the transaction has been completed, the Department will proceed in accordance with N.J.A.C. 7:19-1.5(b).

(h) If the sending party retains diversion rights in excess of 100,000 gallons per day, the reduction in allocation will be considered a minor modification of the permit. Upon receipt of notification that the transfer has been completed, the Department will proceed in accordance with N.J.A.C. 7:19-1.5(b).

7:19-8.8 Adjudicatory hearings

A permittee who believes himself or herself to be aggrieved by a decision of the Department pursuant to this subchapter may request an adjudicatory hearing in accordance with N.J.A.C. 7:19-2.13.

[CHAPTER 19B]
[WATER EMERGENCY SURCHARGE SCHEDULE RULES]

SUBCHAPTER [1.]**9.** ESTABLISHMENT OF WATER SURCHARGE SCHEDULE

[7:19B-1.1]**7:19-9.1** Scope and authority

This [chapter] **subchapter**, adopted pursuant to the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., shall constitute the rules governing the establishment of a water surcharge schedule applicable during a declared state of emergency as mandated by Executive Order No. 5, signed by Governor Thomas Kean on April 27, 1982.

[7:19B-1.2]**7:19-9.2** Purpose

The purpose of this [chapter] **subchapter** is to establish a water surcharge schedule for the retail costs of water supplies during water emergencies, declared by the Governor of the State of New Jersey. The schedule will be utilized by all applicable water purveyors in the event of such a declared emergency.

[7:19B-1.3 Definitions

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

"Act" means the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq.

"Applicable water purveyors" means all public-community water systems' purveyors serving those areas in which Phase II of the water emergency has been initiated.

"Commissioner" means the Commissioner of the Department of Environmental Protection or his designated representative.

"Customer of record" means any person, corporation, company, partnership firm, association, political subdivision of the State and any state, or interstate agency or Federal agency receiving water service from an applicable water purveyor.

"Department" means the Department of Environmental Protection.

"Drought coordinator" means the individual designated by the Commissioner responsible for the supervision of the administration and enforcement of this chapter.

"Non-residential users" means all users of water other than residential users.

"Normal water rates" means the prevailing retail rates which were charged by the applicable water purveyors and which were in effect immediately preceding the declaration of a water emergency.

"Phase I" means the first stage of a declared water emergency during which available water supply levels are determined to be below normal and bans on adjustable water uses may be instituted, as provided by regulation.

"Phase II" means the second stage of a declared water emergency during which a more substantial threat to the public health and welfare exists and a specified reduction in water use may be mandated.

"Residential users" means all users of water who reside in a single structure, housing no more than four families, and in multiple family dwellings with no more than four families being serviced by one meter. (In any circumstance when residential and non-residential users served by the same meter, the users shall be classified as non-residential users.)"

"Water emergency" means a declaration by the Governor, upon a finding by the Commissioner, that there exists or impends a water supply shortage and/or water quality emergency, which significantly impacts water supply and, thereby, endangers the public health, safety or welfare in all or in any part of the State.

"Water emergency fund" means that repository of all sums collected by the applicable water purveyors pursuant to the water emergency surcharge schedule which are in excess of the amounts which would have been collected under normal water rates.

[7:19B-1.4 Applicability

This chapter shall be applied to all persons serviced by all applicable purveyors.]

Recodify existing 7:19B-1.5 through 1.7 as **7:19-9.3 through 9.5** (No change in text.)

[7:19B-1.8]**7:19-9.6** Exemption from the water emergency surcharge schedule

Exemptions from water rationing requirements in this [chapter] **subchapter** may be granted by the Department according to the procedures and standards in N.J.A.C. [7:19A-9.2] **7:19-10.**

[7:19B-1.9 Penalties

Failure to comply with any requirement of the Act including but not limited to a violation of any rule, license, permit, administrative order or this chapter may result in a penalty in accordance with N.J.A.C. 7:14-8.]

[CHAPTER 19A]
[EMERGENCY WATER SUPPLY ALLOCATION PLAN REGULATIONS]

[SUBCHAPTER 1. GENERAL PROVISIONS

7:19A-1.1 Scope and authority

This chapter, adopted pursuant to the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., constitutes the rules governing the management of the waters of the State during drought warnings, water supply emergencies, and water quality emergencies severe enough to constitute a water supply emergency. This chapter partially implements the emergency provisions under the Act; however, it in no way limits the emergency powers now or hereafter vested in the Governor or Commissioner.

7:19A-1.2 Construction

(a) This chapter shall be liberally construed to permit the Department to discharge its statutory functions, and to effectuate the purposes of the Act.

(b) The Commissioner may amend, repeal, or rescind this chapter from time to time to conformance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

7:19A-1.3 Purpose

(a) This chapter is promulgated for the following purposes:

1. To impose water usage restrictions during a declared state of water emergency;

2. To create a priority system for the order i which restrictions shall be imposed upon the various categories of water uses;

3. To ensure an adequate supply and quality of water for citizens of the State during water supply and water quality emergencies;

4. To protect the public health, safety, and welfare in all or any part of the State in which a declared state of water emergency exists;

5. To establish a Water Emergency Task Force;

6. To establish a procedure whereby departmental orders issued during a declared state of water emergency may be appealed;

7. To establish a procedure for the selective curtailment of water to large industrial users;

8. To establish procedures for setting rates for transfers of water including those mandated by the Commissioner and a process to resolve conflicts regarding same; and

9. To establish application procedures for hardship exemption from the ban on adjustable water uses and the requirements of the water rationing plan.

7:19A-1.4 Definitions

For the purposes of this chapter, the following definitions shall apply, unless the context clearly indicates a different meaning:

"Act" means the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq.

"Adjustable water use ban" means the prohibition or restriction of various uses of water as defined in "Adjustable water uses".

"Adjustable water uses" means, but is not limited to, the following:

1. The watering of all plant growth, except commercially grown food crops;

2. The washing of vehicles, except by businesses engaged exclusively in car washing on its own business site, including self-service car washés equipped with total recycle of both wash and rinse water, or in those instances where a threat to public health may exist;

3. The washing of streets, driveways, sidewalks or paved areas;

4. The serving of water in restaurants, clubs or eating places unless specifically requested by the patron;

5. The use of water for flushing sewers by municipalities or any public or private entity except as deemed necessary and approved in the interest of public health or safety by municipal health officials;

6. The use of fire hydrants by fire companies for testing fire apparatus and for fire department drills except as deemed necessary in the interest of public safety and specifically approved by the municipal governing body and the purveyor;

7. The use of fire hydrants by municipal road departments, contractors and all others, except as necessary for fire fighting or protection purposes;

8. All outdoor recreational purposes;

9. The washing of buildings or other structures, except for windows; and

10. Any other uses of water as may be designated by the Commissioner as adjustable. Such designations shall be made by rule or order and shall be effective immediately upon adoption by the Commissioner and shall be published in the New Jersey Register as soon thereafter as possible;

11. Exemptions from the adjustable water uses as listed herein may be designated by the Commissioner as provided for at N.J.A.C. 7:19A-9.1.

"Chairman" means the Chairman of the Water Emergency Task Force who shall be designated by the Commissioner.

"Commissioner" means the Commissioner of the New Jersey Department of Environmental Protection or his designated representative.

"Department" means the New Jersey Department of Environmental Protection.

"Division" means the Division of Water Resources of the New Jersey Department of Environmental Protection.

"Drought warning" means the status declared by the Department, pursuant to N.J.A.C. 7:19A-5.1, where there exists a relative lack of precipitation or a lower than normal storage of water supplies.

"Emergency response plan" means the document submitted by each water purveyor to the Department outlining the actions it will take to assure water supply during a water emergency.

"Industrial users" means those non-residential users excluding multiple dwellings and health care facilities.

"Non-residential users" means all users of water other than residential users.

"Passing flow requirements" means the minimum volume of water required to be maintained at a selected point to promote water quality conditions after consideration of the needs of downstream users.

"Phase" means the particular level of water emergency severity.

"Residential users" means all users of water who reside in a single structure, housing no more than four families, and in multiple family dwellings with no more than four families being serviced by one meter. (In any circumstance where residential and non-residential users are served by the same meter, the users shall be classified as non-residential users.)

"Water emergency" means a declaration by the Governor upon a finding by the Commissioner, that there exists or impends a water supply shortage and/or water quality emergency of a dimension which significantly impacts water supply and, thereby, endangers the public health, safety or welfare in all or any part of the State.

"Water Emergency Surcharge Schedule" means the rate schedule for the retail costs of water supplies which shall be utilized by applicable water purveyors, as provided by rule, in the event of a declared emergency.

"Water Emergency Task Force" or "Task Force" means that State body consisting of inter-agency representatives whose purpose is to assist the Commissioner in the formulation of policy and make recommendations to the Commissioner during a water emergency. The Task Force shall be composed of representatives of the following agencies: the Department of Environmental Protection, the Department of Commerce and Economic Development, the Department of Education, the Department of Labor, the Department of Law and Public Safety, the Department of Community Affairs, the

Board of Public Utilities, the Department of Agriculture, the Department of Health, the Department of Treasury and other agencies as designated by the Commissioner.

"Water purveyor" means any public or private organization that distributes potable water to the public.

"Water supply system" means a physical infrastructure operated and maintained to deliver water on either a retail or wholesale basis to customers.

7:19A-1.5 Severability

If any section, subsection, provision, clause, or portion of this chapter is adjudged unconstitutional or invalid by a court of competent jurisdiction, the remainder shall not be affected thereby.]

SUBCHAPTER [2.]**10.** POWERS OF THE COMMISSIONER DURING A [STATE OF] WATER EMERGENCY

Recodify existing 7:19A-2.1 and 2.2 as **7:19-10.1 and 10.2** (No change in text.)

[7:19A-2.3]**7:19-10.3** Requirements placed on departments and agencies within State government

After a determination by the Commissioner and after notice to the appropriate State government body, agency, department, said body, agency, or department shall provide immediately, any information, assistance, resources and personnel as shall be necessary for the Commissioner to discharge his **or her** functions and responsibilities under the Act or this [chapter] **subchapter**.

SUBCHAPTER [3.]**11.** GENERAL POWERS OF THE DEPARTMENT

Recodify existing 7:19A-3.1 and 3.5 as **7:19-11.1 through 11.5** (No change in text.)

[7:19A-3.6]**7:19-11.6** Drought warning requirements

(a) During a drought warning condition identified in accordance with N.J.A.C. [7:19A-5.1(d)] **7:19-13.1(d)**, the Department may order water purveyors to comply with any or all of the following requirements:

1.-5. (No change.)

SUBCHAPTER [4.]**12.** WATER EMERGENCY TASK FORCE

Recodify existing 7:19A-4.1 and 4.2 as **7:19-12.1 and 12.2** (No change in text.)

SUBCHAPTER [5.]**13.** THE PRIORITY-BASED PHASE SYSTEM OF WATER RESTRICTIONS

[7:19-5.1]**7:19-13.1** Scope

(a)-(c) (No change.)

(d) Prior to actual declaration of a water supply emergency by the Governor, the Department may call for action to be taken under its non-emergency powers in order to reduce the likelihood or impact of any impending emergency. Where such situations involve a relative lack of precipitation or a lower than normal storage of water supplies, the Department may identify the affected area or the State as a whole as being in a "Drought Warning" condition. The Department shall give notice of and hold a public hearing prior to implementing any of the drought warning requirements in N.J.A.C. [7:19A-3.6] **7:19-11.6**.

(e) Where the Delaware River Basin Commission, in accordance with its rules and procedures, declares a drought emergency based upon the storage in New York City's Delaware Basin reservoirs, thereby impacting the New Jersey portion of the Delaware Basin, the Governor may also declare a water emergency in the New Jersey portion of the Basin. The Department shall coordinate with the DRBC **concerning** the implementation of this [chapter] **subchapter** and the Water Emergency Surcharge Schedule, N.J.A.C. [7:19B] **7:19-9**.

(f) (No change.)

[7:19A-5.2]**7:19-13.2** (No change in text.)

[7:19A-5.3]**7:19-13.3** Phase I: Available water supply levels determined to be below normal

(a) (No change.)

(b) A ban on adjustable water uses may be instituted at this phase. **Such adjustable uses include:**

1. The watering of all plant growth, except commercially grown food crops;

2. The washing of vehicles, except by businesses engaged exclusively in car washing on site, including self-service car washes equipped with total recycle of both wash and rinse water, or in those instances where a threat to public health may exist;

3. The washing of streets, driveways, sidewalks or paved areas;

4. The serving of water in restaurants, clubs, or eating places unless specifically requested by patrons;

5. The use of water for flushing sewers by municipalities or any public or private entity except as municipal health officials deem necessary in the interest of public health or safety;

6. The use of fire hydrants by fire companies for testing fire apparatus and for fire department drills except as the municipal governing body and the purveyor deem necessary in the interest of public safety;

7. The use of fire hydrants by municipal road departments, contractors, and all others, except as necessary for fire fighting or protection purposes;

8. The use of water for all outdoor recreational purposes;

9. The washing of buildings or other structures, except for windows; and

10. Any other uses of water as the Commissioner may designate. The Commissioner shall effect such designations by administrative order and such designations shall be effective immediately upon adoption by the Commissioner and shall be published in the New Jersey Register as soon thereafter as possible.

(c) (No change.)

(d) Any person wishing to be exempt from the ban on adjustable water uses shall file an application for a hardship exemption in accordance with N.J.A.C. [7:19A-9.1] **7:19-16.1**.

(e) (No change.)

[7:19A-5.4]**7:19-13.4** Phase II: Severity; substantial threat to the public health and welfare

(a) Non-residential users shall be subject to the water emergency rate schedule as provided by rule. (See N.J.A.C. [7:19B] **7:19-9**).

(b)-(c) (No change.)

(d) Any person wishing to be exempt from the requirements of this section shall file an application for a hardship exemption in accordance with N.J.A.C. [7:19A-9.2] **7:19-16.2**.

[7:19A-5.5]**7:19-13.5** Phase III: Further rationing required

This stage requires further rationing of water supplies to all sectors or the selective curtailment of industrial water users in accordance with N.J.A.C. [7:19A-6] **7:19-14**.

[7:19A-5.6]**7:19-13.6** (No change in text.)

SUBCHAPTER [6.]**14.** INDUSTRIAL CURTAILMENT STRATEGY

Recodify existing 7:19A-6.1 through 6.3 as **7:19-4.1 through 4.3** (No change in text.)

[7:19A-6.4]**7:19-14.4** Submission of water supply information

Industrial users, water purveyors and other water users, shall submit to the Department, upon its request, all information relating to water consumption and employment required by N.J.A.C. [7:19A-3.4, 3.5, 6.2 and 6.3] **7:19-11.4, 11.5, 14.2 and 14.3**.

[SUBCHAPTER 7. PENALTIES

7:19A-7.1 Penalties

Failure by any person to comply with any requirement of the Act including, but not limited to, a violation of any rule, license, permit, administrative order or this chapter may result in a penalty in accordance with N.J.A.C. 7:14-8.]

SUBCHAPTER [8.]**15.** EMERGENCY WATER TRANSFER PRICING

Recodify existing 7:19A-8.1 through 8.3 as **7:19-15.1 through 15.3** (No change in text.)

SUBCHAPTER [9.]**16.** HARDSHIP EXEMPTION PROCEDURES

[7:19A-9.1]**7:19-16.1** Application procedures for hardship exemption from the ban on adjustable water uses

(a) Any person wishing to be exempt wholly or partially from the ban on adjustable water uses may apply for a hardship exemption according to the following procedures:

1. The applicant shall submit his **or her** request along with full documentation supporting the request to the attention of the Water Emergency Task Force at the [Division.] **following address:**

Water Emergency Task Force
c/o Water Supply Element
CN 426
Trenton, New Jersey 08625

2.-4. (No change.)

[7:19A-9.2]**7:19-16.2** Application procedures for hardship exemption from the requirements of water rationing

(a) Any person wishing to be exempt from the requirements of water rationing may, within 30 days following receipt of the surcharge bill issued pursuant to N.J.A.C. [7:19B] **7:19-9**, file an application for a hardship exemption with the appropriate water purveyor according to the following procedures:

1.-6. (No change.)

(b)-(c) (No change.)

SUBCHAPTER [10.]**17.** DEPARTMENT ORDERS

[7:19A-10.1]**7:19-17.1** Requirements for [departmental] **Departmental** orders issued during a [state of] water emergency

(a) All [departmental] **Departmental** orders issued pursuant to [this chapter shall] **N.J.A.C. 7:19-9 through 17 will** be based upon fair compensation, reasonable rate relief, and just and equitable terms.

(b) (No change.)

[7:19A-10.2]**7:19-17.2** Appeal procedure

[(a)] The party to whom an order has been issued[, and/or aggrieved] by [a decision of] the Department [order], shall have a right to request a hearing thereon, [if requested in writing] **by submitting a letter requesting an adjudicatory hearing, pursuant to N.J.A.C. 7:19-2.13, to the Department** within 20 days of receipt of the order.

[(b) For 30 days following receipt of the request for a hearing, the Department shall attempt to settle the dispute by conducting such proceedings, meetings and conferences as deemed appropriate.

(c) If such efforts at settlement fail the Department shall file the request for hearing with the Office of Administrative Law.

(d) The hearing shall be held in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(e) The decision by the Commissioner, based upon the hearing record shall be the final administrative decision concerning an order.]

SUBCHAPTER 18. CIVIL ADMINISTRATIVE PENALTIES AND REQUESTS FOR ADJUDICATORY HEARINGS

7:19-18.1 Authority and purpose

This subchapter governs the Department's assessment of civil administrative penalties for the violation of any provision of the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., or any regulation, rule, permit or order adopted or issued by the Department pursuant thereto. This subchapter also governs the procedure for assessment, settlement and payment of civil administrative penalties and for requesting an adjudicatory hearing on a notice of civil administrative penalty assessment or an administrative order.

7:19-18.2 Procedures for assessment, settlement and payment of civil administrative penalties for violations

(a) To assess a civil administrative penalty under the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., the Department shall notify the violator by certified mail (return receipt requested) or by personal service. This notice of civil administrative penalty assessment (NOCAPA) shall:

1. Identify the section of the statute, rule, administrative order or permit violated;

2. Concisely state the alleged facts which constitute the violation;

3. Specify the amount of the civil administrative penalty to be imposed; and

4. Advise the violator of the right to request an adjudicatory hearing pursuant to the procedures in N.J.A.C. 7:19-18.3.

(b) Payment of the civil administrative penalty is due upon receipt by the violator of the Department's final order in a contested case, or when a notice of civil administrative penalty assessment becomes a final order, as follows:

1. If no hearing is requested pursuant to N.J.A.C. 7:19-18.3, a notice of civil administrative penalty assessment becomes a final order and is deemed received on the 21st day following receipt of the notice of civil administrative penalty assessment by the violator;

2. If the Department denies the hearing request pursuant to N.J.A.C. 7:19-18.3(b), a notice of civil administrative penalty assessment becomes a final order and is deemed received on the 21st day following receipt of the notice of civil administrative penalty assessment by the violator;

3. If the Department denies the hearing request pursuant to N.J.A.C. 7:19-18.3(c), a notice of civil administrative penalty assessment becomes a final order upon receipt of notice of such denial; or

4. If the Department grants the hearing request, a notice of civil administrative penalty assessment becomes a final order upon receipt by the violator of a final order in a contested case.

(c) The Department may, in its discretion, settle any civil administrative penalty assessed pursuant to N.J.A.C. 7:19-18.4, 18.5 or 18.6 according to the following factors:

1. Mitigating or extenuating circumstances not previously considered in the notice of civil administrative penalty assessment pursuant to N.J.A.C. 7:19-18.4(d)7, 18.5(c)6 or 18.6(d)6;

2. The timely implementation by the violator of measures leading to compliance not previously considered in the assessment of penalties pursuant to N.J.A.C. 7:19-18.4(d)5, 18.5(c)5 or 18.6(d)5;

3. The full payment by the violator of a specified part of the civil administrative penalty assessed if made within a time period established by the Department in an administrative order and/or a notice of civil administrative penalty assessment and provided that the violator waives the right to request an adjudicatory hearing on the civil administrative penalty; and/or

4. Any other terms or conditions acceptable to the Department.

7:19-18.3 Procedures to request an adjudicatory hearing to contest an administrative order and/or a notice of civil administrative penalty assessment; procedures for conducting adjudicatory hearings

(a) To request an adjudicatory hearing to contest an administrative order and/or a notice of civil administrative penalty assessment issued pursuant to the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., the violator shall submit the following information in writing to the Department at Office of Legal Affairs, ATTENTION: Adjudicatory Hearing Requests, Department of Environmental Protection, CN 402, Trenton, New Jersey 08625-0402:

1. The name, address, and telephone number of the violator and its authorized representative;

2. The violator's defenses to each of the findings of fact stated in short and plain terms;

3. An admission or denial of each of the findings of fact. If the violator is without knowledge or information sufficient to form a belief as to the truth of a finding, the violator shall so state and

this shall have the effect of a denial. A denial shall fairly meet the substance of the findings denied. When the violator intends in good faith to deny only a part or a qualification of a finding, the violator shall specify so much of it as is true and material and deny only the remainder. The violator may not generally deny all of the findings but shall make all denials as specific denials of designated findings. For each finding the violator denies, the violator shall allege the fact or facts as the violator believes it or them to be;

4. Information supporting the request and specific reference to or copies of other written documents relied upon to support the request;

5. An estimate of the time required for the hearing (in days and/or hours); and

6. A request, if necessary, for a barrier-free hearing location for physically disabled persons.

(b) If the Department does not receive the written request for a hearing within 20 days after receipt by the violator of the notice of a civil administrative penalty assessment and/or an administrative order being contested, the Department shall deny the hearing request.

(c) If the violator fails to include all the information required by (a) above, the Department may deny the hearing request.

(d) All adjudicatory hearings held pursuant to this section shall be conducted in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

7:19-18.4 Civil administrative penalty determination; general

(a) The Department may, in its discretion, assess a civil administrative penalty pursuant to this section of not more than $5,000 per day for each violation of each provision of the Water Supply Management Act, N.J.S.A. 58A-1 et seq., or of any regulation, rule, permit or order adopted or issued by the Department pursuant thereto. The Department shall assess penalties under this section in lieu of N.J.A.C. 7:19-18.5 or 18.6 when N.J.A.C. 7:19-18.5 or 18.6 is not applicable to the violation.

(b) The Department shall consider each violation of each provision of the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., or of any regulation, rule, permit or order adopted or issued by the Department pursuant thereto, as a separate and distinct violation. If the violation is of a continuing nature, each day during which a violation continues shall constitute an additional, separate and distinct violation subjecting the violator to the penalty schedule set forth in (c) below.

(c) The Department may assess a civil administrative penalty for each violation of each provision of the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., or any regulation, rule, permit or order adopted or issued by the Department pursuant thereto at the midpoint of the following ranges except as adjusted pursuant to (d) below:

1. For the first violation of a provision, $0 to not more than $1,000;

2. For the second violation of the same provision, $0 to not more than $2,500; and

3. For the third and subsequent violations of the same provision, $0 to not more than $5,000.

(d) The Department may, in its discretion, adjust the amount determined pursuant to (c) above to assess a civil administrative penalty in an amount no greater than the maximum amount nor less than the minimum amount in the range described in (c) above, on the basis of any or a combination of the factors listed in (d)1 through 7 below. No such factor constitutes a defense to any violation:

1. The compliance history of the violator;

2. The number, frequency and severity of the violations;

3. The measures taken by the violator to mitigate the effects of the current violation or to prevent future violations;

4. The deterrent effect of the penalty;

5. The cooperation of the violator in correcting the violation, remedying any environmental damage caused by the violation and ensuring that the violation does not recur;

6. Any unusual or extraordinary costs directly or indirectly imposed on the public by the violation; and/or

7. Any other extenuating, mitigating or aggravating circumstances.

7:19-18.5 Civil administrative penalties for failure to allow lawful entry and inspection

(a) The Department may, in its discretion, assess a civil administrative penalty of $5,000 against each violator who refuses, inhibits or prohibits immediate lawful entry and inspection of any premises, building or place by any authorized Department representative.

(b) Each day, from the initial day on which the violator refuses, inhibits or prohibits immediate lawful entry and inspection by any authorized Department representative up to and including the day on which the Department receives written notification from the violator that the violator will not refuse, inhibit or prohibit immediate lawful entry and inspection, shall constitute an additional, separate and distinct violation.

(c) The Department may, in its discretion, reduce a civil administrative penalty determined pursuant to (a) on the basis of any or a combination of the factors listed in (c)1 through 6 below. No such factor constitutes a defense to any violation:

1. The compliance history of the violator;

2. The number, frequency and severity of the violations;

3. The measures taken by the violator to prevent future violations;

4. The deterrent effect of the penalty;

5. The cooperation of the violator in correcting the violation and ensuring that the violation does not recur; and/or

6. Any other extenuating, mitigating or aggravating circumstances.

7:19-18.6 Civil administrative penalties for submitting inaccurate or false information

(a) The Department may, in its discretion, assess a civil administrative penalty against each violator who submits inaccurate information or who makes a false statement, representation or certification in any application, record or other document required to be submitted or maintained under the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., or any regulation, rule, permit or order adopted or issued by the Department pursuant thereto, or who fails to submit or maintain any application, record, or other document required to be submitted or maintained under the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., or any regulation, rule, permit or order adopted or issued by the Department pursuant thereto, or who falsifies, tampers with or renders inaccurate any monitoring device or method required to be maintained by the Water Supply Management Act, N.J.S.A. 58:1A-1 et seq., or any regulation, rule, permit or order adopted or issued by the Department pursuant thereto at the midpoint of the ranges in (c) below except as adjusted pursuant to (d) below:

(b) Each day, from the day on which the violator submits the inaccurate information or false statement, representation or certification to the Department up to and including the day on which the Department receives a written correction of the inaccurate information or false statement, representation or certification, shall constitute an additional, separate and distinct violation.

(c) The Department shall determine the amount of the civil administrative penalty based on the conduct of the violator as follows:

1. For any intentional, deliberate, purposeful, knowing or willful act or omission by the violator, the civil administrative penalty shall be in an amount of not more than $3,000 nor less than $1,000;

2. For any unintentional but foreseeable act or omission the civil administrative penalty shall be in amount not more than $1,500 nor less than $500.00; or

3. For any other violation the civil administrative penalty shall be in an amount not more than $1,000.

(d) The Department may, in its discretion, adjust the amount determined pursuant to (c) above to assess a civil administrative penalty in an amount no greater than the maximum amount nor less than the minimum amount in the range described in (c) above, on the basis of any or a combination of the factors listed in (d)1

through 6 below. No such factor constitutes a defense to any violation:

1. The compliance history of the violator;

2. The number, frequency and severity of the violations;

3. The measures taken by the violator to prevent future violations;

4. The deterrent effect of the penalty;

5. The cooperation of the violator in correcting the violation and ensuring that the violation does not reoccur; and/or

6. Any other extenuating, mitigating or aggravating circumstances.

(a)

COMMISSION ON RADIATION PROTECTION DEPARTMENT OF ENVIRONMENTAL PROTECTION BUREAU OF ENVIRONMENTAL RADIATION

Radiation Protection

Proposed Readoption with Amendment: N.J.A.C. 7:28

Proposed Repeal: N.J.A.C. 7:28-12

Authorized By: Robert C. Shinn, Jr., Commissioner, Department of Environmental Protection, and Commission on Radiation Protection, Dr. Henry J. Powsner, Chairman.

Authority: N.J.S.A. 26:2D-1 et seq., specifically 26:2D-7, 26:2D-9 and 26:2D-21.

DEP Docket Number: 50-94-11/111.

Proposal Number: PRN 1994-659.

Submit written comments by January 18, 1995 to:

Janis E. Hoagland, Esq.
DEP Docket Number: 50-94-11/111
Administrative Practice Officer
New Jersey Department of Environmental Protection
Office of Legal Affairs
CN 402
Trenton, New Jersey 08625-0402

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), the radiation protection rules, N.J.A.C. 7:28, expire on July 30, 1995. The Commission on Radiation Protection ("Commission") and the Department of Environmental Protection ("Department") have reviewed these rules and have determined that their continuation is necessary for the purposes for which they were originally promulgated. The Department and Commission note that they are developing substantial revisions to N.J.A.C. 7:28-1 through 17 to update the rules regarding radioactive materials and machine sources of ionizing radiation to bring them into parallel with relevant Federal requirements and to reflect recent scientific advances. In the meantime, however, the existing rules must be readopted in order to assure continuation of the radiation protection program."

The rules in N.J.A.C. 7:28 address many areas of radiation protection including radioactive materials, machine sources of ionizing radiation, nuclear power plants, businesses that provide radon testing and mitigation, nonionizing radiation and licensing of radiologic technologists and nuclear medicine technologists. The rules cover such areas as obtaining licenses and registrations, reporting requirements, waste management standards, personnel monitoring, operating standards, recordkeeping and fees for various services.

Radiation is a hazard because the energy or particles given off can react directly with protein molecules or DNA in cells. While some damage can be corrected by cellular repair mechanisms, the more damage that has been done, the greater the possibility of mutations, cell malfunction or cell death.

Radiation can pose different kinds of health risks. It is difficult to accurately assess the risks from different doses of radiation when some serious consequences, such as cancer and genetic effects, may not be observed for many years. Because the effect of low doses of radiation is not known and may not be immediately visible, it is prudent to keep radiation doses as low as possible.

Effective regulatory control contributes to minimizing unnecessary radiation and its attendant risks. For medical uses of radiation, regulatory controls decrease unnecessary radiation exposures while retaining the medical benefits from the procedure. Through a quality assurance program the staff at a facility can ensure, for example, that the images produced are of sufficiently high quality to consistently provide adequate diagnostic information with the least possible radiation exposure for the patient. A quality assurance program includes many components from machine calibration to staff and operator education. According to the National Council on Radiation Protection (NCRP) Report #100 (dated 5/1/89), a quality assurance program incorporating "good practices" may lead to mean whole body dose reductions of up to 50 percent. Specific "good practice" procedures such as assuring optimum x-ray beam collimation, filtration and source to subject distance can reduce doses by factors of from 1.5 to four. In mammography procedures dose reduction factors of 1.3 to five can be achieved through optimum equipment usage and proper technique. The full realization of these dose reductions can be achieved through an integrated effort comprising the state radiation regulatory program and the cooperation of medical practitioners.

Through the regulatory program and inspections the Department will continue to provide a framework for a basic quality assurance program for activities involving the use of radiation.

The rules contribute to this in a number of ways. For example, rules which establish education and experience requirements for authorized users and Radiation Safety Officers and requirements for licensing radiologic and nuclear medicine technologists ensure that only properly trained, experienced personnel will handle sources of radiation. Through its system of inspections the Department determines that machine sources of ionizing radiation are properly calibrated and collimated and that proper management and waste disposal methods are being employed for radioactive materials. During inspections licensees and registrants are made aware of problems which may contribute to unnecessary radiation exposures to patients, workers and the general public. If significant problems are found and not corrected, the Department can take action under the regulations to revoke a license registration or other authorization in order to protect the public.

The following is a summary of the content of each subchapter in N.J.A.C. 7:28 and the subchapter proposed for repeal.

In December 1993, the Department also proposed new rules establishing fees for the registration of sources of nonionizing radiation (broadcast antennae, industrial heaters and sealers). See N.J.R. 5422(a). The adoption notice for these readopted rules will reflect the new subchapter 48, which the Department anticipates will be adopted, in part, by December 6, 1994.

N.J.A.C. 7:28-1 General Provisions

This subchapter defines the purpose and scope of N.J.A.C. 7:28 and states that the rules in Chapter 28 shall be liberally construed to permit the Department, the Radiation Protection Programs and its various agencies to discharge their statutory function. This subchapter also defines words and terms used throughout the chapter. The subchapter also lists the telephone numbers for emergency notifications of incidents involving sources of radiation and addresses for routine submittals.

N.J.A.C. 7:28-2 Use Of Sources Of Ionizing Radiation And Special Exemptions

This subchapter requires that all persons who use, operate, receive, possess, dispose of, transfer, install, transport or store sources of ionizing radiation must comply with the requirements of N.J.A.C. 7:28. This subchapter also establishes the conditions that must be met for the use of sources of radiation including: criteria for supervision, instruction for all persons working in or frequenting the vicinity of ionizing radiation-producing machines or radioactive materials, restrictions on the use of certain radiation-producing equipment, licensing of persons who arrange for intentional human irradiation and the institution of emergency precautions based on a study of potential radiation hazards. The subchapter sets forth the Department's right to inspect any source of radiation and its operation, to inspect the facility and premises where sources of radiation are located, to examine records and to require tests which it deems necessary for the administration of this chapter. This subchapter also allows the Department, with the approval of The Commission, to grant special exemptions from the rules upon application by an individual who shows proof of hardship or compelling need why a rule requirement cannot be met. The Commission must determine that granting such an exemption would not result in exposure to radiation in excess of the limits, specified in N.J.A.C. 7:28-6, before it can approve such an exemption. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-3 Registration Of Ionizing Radiation-Producing Machines And Radioactive Materials

This subchapter addresses the requirements for registering all ionizing-radiation-producing machines within the State of New Jersey. These requirements include the registration application process, notification requirements for registration amendments, the process for temporary registrations, and notification requirements in the event of the sale, installation, relocation or disposal of an ionizing radiation-producing machine. This subchapter also establishes the fee structure for the initial registration application and for the annual registration renewal for ionizing radiation-producing machines. An amendment to the fee schedule at N.J.A.C. 7:28-3.12 was proposed on September 19, 1994 at 26 N.J.R. 3797(a). The adoption notice for these readopted rules will reflect the amended fee schedule if it is adopted. The subchapter lists those machine sources and radioactive materials that are exempt from the registrations process. The subchapter requires the registration of radioactive by-product, source and special nuclear radioactive materials that are licensed by the U.S. Nuclear Regulatory Commission (NRC). The subchapter prohibits the transfer of registrations and requires that registrants notify the Department of any changes to an NRC license and amend their State registration. This subchapter contains the criteria for denying, suspending or revoking a registration. This subchapter was amended on August 5, 1991 at 23 N.J.R. 2362(a). The amendments addressed the registration of NRC licensed materials and the fees for registering those materials.

N.J.A.C. 7:28-4 Licensing Of Naturally Occurring And Accelerator Produced Radioactive Materials

This subchapter establishes the requirements to obtain a general or specific state license for the production, transfer, receipt, acquisition, ownership, possession or use of any naturally occurring or accelerator produced radioactive materials. The subchapter includes general and special requirements for obtaining approval of initial licenses, obtaining amendments to and renewal of licenses and expiration of licenses. This subchapter also establishes the terms and conditions of general and specific State licenses that must be met. Among these terms and conditions are the requirements that records be kept by the licensee, the obligation to allow the Department access to a licensed facility for inspections and the requirement that tests on radioactive materials, on facilities which store or use radioactive materials, or on radiation equipment must be performed. The subchapter also contains the fees for licenses. The procedures for modification, revocation, suspension and termination of licenses of general and specific licenses are listed. This subchapter also establishes the rules that allow the applicant for a license to file a confidentiality claim to cover information which the applicant considers trade secrets. The fees in this subchapter were amended on August 5, 1991 at 23 N.J.R. 2362(a).

N.J.A.C. 7:28-5 Controlled Areas

This subchapter establishes the criteria for defining and designating a controlled area. Pursuant to this subchapter, a controlled area is one in which there is a reasonable possibility that an occupant may receive a dose from a source of radiation in excess of the limits specified in N.J.A.C. 7:28-6.2. The subchapter addresses the use of residential quarters as controlled areas. It establishes the precautionary measures to be taken to ensure that radiation levels do not exceed those allowed under N.J.A.C. 7:28-6. The subchapter also sets forth the conditions that must be met to reclassify a controlled area as an uncontrolled area. This subchapter has not been amended since it was readopted July 30, 1990.

N.J.A.C. 7:28-6 Permissible Dose Rates, Radiation Levels And Concentrations

This subchapter establishes the maximum dose an individual in a controlled area may receive in a calendar quarter, 1.25 rem. It requires that radiation levels at any point outside a controlled area must be limited to a level at which there is no reasonable possibility of an individual receiving a radiation dose to the whole body, head and trunk, active blood-forming organs, gonads or lens of the eye in excess of 0.5 rem in any one year. This subchapter requires that concentrations of radioactive materials in effluents from controlled areas not exceed the limits specified in N.J.A.C. 7:28-11.2 and 11.3. The maximum permissible average concentrations of radioactive materials in air and water are also established. The procedures to be followed when individuals are exposed to radiation at a level which exceeds the limits specified in N.J.A.C. 7:28-6.1(a) as a result of a radiation incident or emergency are set forth. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-7 Radiation Surveys And Personnel Monitoring

This subchapter establishes the requirements for performing radiation surveys of controlled and uncontrolled areas to determine compliance with the radiation exposure limits specified in N.J.A.C. 7:28-6. In addition, this subchapter establishes the requirement that owners of installations where radioactive materials are used or stored require and provide personnel monitoring equipment for each individual entering a controlled area under the circumstances described in N.J.A.C. 7:28-7.4(a). The subchapter requires licensees to perform bioassays to determine the amount of radioactive material ingested or inhaled when the Department requests it. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-8 Records

This subchapter establishes the recordkeeping requirements for personnel monitoring of radiation exposure, radiation surveys, radioactive materials installations, sealed source testing results and discontinued radiation installations. The subchapter requires that information obtained from personnel monitoring equipment be compiled into clear, legible records. These records must be maintained at the installation and made available to the Department, current employees and former employees. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-9 Radioactive Contamination Control

This subchapter establishes the requirements for minimizing radioactive contamination of objects and personnel in areas where radioactive materials are used or stored. These requirements apply to all owners of installations where radioactive materials are used or stored. The subchapter also addresses personnel and material contamination limits, criteria for decontamination of premises and sealed source testing requirements. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-10 Labeling, Posting And Controls

This subchapter establishes the specifications for the conventional radiation caution symbol that appears on signs required to be posted in areas when sources of radiation are being used, stored or transported. Under this subchapter certain situations are exempted from the posting and labeling requirements. The subchapter requires that equipment containing radioactive materials which is being used, stored or transported must be labeled. The subchapter describes when labels and signs must be removed. It has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-11 Disposal Of Radioactive Materials

This subchapter establishes the requirements and conditions for the disposal of radioactive waste. The methods addressed by this subchapter include disposal by: release into a sanitary sewer system, burial in soil, transfer to a radioisotope disposal service, incineration and specially approved methods. This subchapter also requires that sources of radiation in storage be secured to prevent unauthorized removal. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-12 Transportation

This subchapter establishes the requirements for the transportation of radioactive materials. Currently, this subchapter contains requirements for obtaining a Certificate of Handling for shipping certain radioactive materials within or through the state of New Jersey. However, the Federal Hazardous Materials Uniform Transportation Safety Act (HMTUSA) has pre-empted the portion of the State Radiation Protection Act that authorized the Department to issue Certificates of Handling. In consideration of this Federal pre-emption, N.J.A.C. 7:28-12 is being proposed for repeal.

N.J.A.C. 7:28-13 Report Of Thefts And Radiation Incidents

This subchapter establishes requirements for reporting the theft or loss of radioactive material to the Department. Licensees and registrants must report to the Department any loss or theft of radioactive materials and any radiation incident which may have caused or which threatens to cause: (1) exposure of the whole body of any individual to 25 rems of radiation or more, exposure of the skin of the whole body of an individual

to 150 rems or more or exposure to the feet, ankles, hands or forearms of any individual to 375 rems of radiation or more; (2) the release of radioactive material in concentrations, which if averaged over a period of 24 hours, would exceed 5,000 times the limits specified for such material in N.J.A.C. 7:28-6.5; (3) a loss of one working week or more of the operation of the affected facility; or (4) damage to property in excess of $100,000. This subchapter also establishes the reporting requirements for radiation incidents involving exposures of individuals or the environment to radiation levels specified in N.J.A.C. 7:28-13.2(a) and includes specific topics to be addressed in the report. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-14 Therapeutic Installations

This subchapter establishes the requirements for therapeutic installations used in the healing arts. The subchapter establishes machine performance standards for therapeutic X-ray systems and therapeutic accelerator systems, facility radiation safety operating procedures, calibration and spot check requirements and recordkeeping requirements. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-15 Medical Diagnostic X-Ray Installations

The previous version of this subchapter was repealed and the present version was adopted on October 18, 1993 at 25 N.J.R. 4770(a). This subchapter sets performance standards for radiographic equipment used in the healing arts including, per N.J.A.C. 7:28-15.3, requirements for: alignment of the light and X-ray fields, half-value layer, control panel indicators, exposure termination signals and reproducibility. It includes standards for mammography units, including a requirement that the unit be accredited by the American College of Radiography and requires the establishment of a quality assurance (QA) program. The QA program requirements include routine testing and maintenance of equipment to ensure that images are consistently of high quality. The subchapter establishes exposure rate limits for fluoroscopic units and machine performance standards for radiation therapy simulator systems. Computer tomographic systems must comply with safety and operating standards established in this subchapter. The subchapter also sets safety requirements for medical cabinet X-ray systems. The subchapter also addresses requirements for individual radiation safety at radiographic installations such as the use of protective aprons and the prohibition on holding patients during X-ray procedures and safety training. The requirements for shielding for X-rays, installation, conducting radiation surveys of the environs and maintaining reports are found in this subchapter. This subchapter prohibits the use of shoe-fitting fluoroscopes, fixed vertical fluoroscopic systems used for non-image intensified fluoroscopy used for radiographic, non-image intensified fluoroscopy and hand-held fluoroscopic screen and chest photofluorographic X-ray units.

N.J.A.C. 7:28-16 Dental Radiographic Installations

The present version of this subchapter was adopted on September 19, 1990 at 22 N.J.R. 3367. On October 18, 1993 at 25 N.J.R. 4770(a), N.J.A.C. 7:28-16.2 was amended and N.J.A.C. 7:28-16.8 was repealed and replaced with a new rule. This subchapter establishes the safety and operational requirements for dental radiographic installations and prohibits the operation of any dental radiographic equipment in any way that is not in compliance with the subchapter.

The subchapter also establishes safety standards for dental radiographic equipment and it sets standards for multiple dental radiographic tube installations, cephalometric radiographic installations and panoramic radiographic installations. The subchapter requires that dental radiographic equipment may not be operated unless there is adequate, permanent structural shielding.

N.J.A.C. 7:28-17 Industrial And Nonmedical Radiography

This subchapter establishes radiation safety requirements for persons using sealed sources, radiographic exposure devices or ionizing radiation-producing machines for industrial and nonmedical radiography. These requirements include registration or licensing of equipment, equipment control for radiographic-exposure devices and storage containers and equipment control for ionizing radiation-producing machines. This subchapter establishes personnel radiation safety training requirements for radiographers and radiographer's assistants and precautionary procedures to be used during the use of industrial radiographic equipment. It also establishes specific standards for cabinet X-ray systems and shielded room radiography. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-18 Major Nuclear Facilities

This subchapter establishes requirements for the protection of individuals from exposure to radiation in excess of the limits specified in N.J.A.C. 7:28-6.1 and 6.2 that must be met by major nuclear facilities, including nuclear reactors, nuclear fuel fabrication plants, nuclear fuel reprocessing plants and nuclear waste handling or disposal facilities. The subchapter establishes standards to ensure that individuals outside of these facilities receive no radiation exposures from environmental or direct radiation in excess of the limits established in N.J.A.C. 7:28-6. Subchapter 18 requires that any person constructing a major nuclear facility must first submit a general description of the proposed facility, including plans for the required monitoring systems, to the Department. Prior to operation, the facility's emergency plans must be submitted to the Department. It also requires that any radiation incident at a major nuclear facility be reported to the Department. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-19 Medical Exposure To Ionizing Radiation By Radiologic Technologists

This subchapter establishes rules to prohibit and prevent excessive and improper exposure to ionizing radiation through the intentional irradiation of humans. These rules implement N.J.S.A. 26:2D-24 et seq., the Radiologic Technologist Act. This subchapter defines the scope of practice of radiologic technology and establishes the requirements and procedures for obtaining a license to practice radiologic technology. This subchapter establishes the criteria and standards for educational programs of diagnostic, radiation therapy, chest, dental, podiatric, orthopedic and urologic radiography, including the procedure to obtain program approval and accreditation. This subchapter establishes criteria for admitting students to a radiography program and for the use of X-ray equipment by a student. The examination and licensing fees are also listed. Amendments to the fee schedule in this subchapter were adopted on October 15, 1990 at 22 N.J.R. 3227(c). The Department is also making a technical correction at N.J.A.C. 7:28-19.5(b)1. The word "proffered" should have read "preferred" as it does in the Radiologic Technologist Act at N.J.S.A. 26:2D-34(b).

N.J.A.C. 7:28-20 Particle Accelerators For Industrial And Research Use

This subchapter was adopted on February 3, 1992 at 24 N.J.R. 416(a) and was therefore not included in the previous readoption. The subchapter prohibits the operation of a particle accelerator that does not meet the standards of N.J.A.C. 7:28-20 or that is not registered with the Department. The subchapter establishes the requirement that the registrant appoint a particle accelerator safety office and a radiation protection committee. Under this subchapter prior approval from the Department is required for the use of a particle accelerator in the healing arts. The subchapter requires that each operator complete a particle accelerator safety training course. The subchapter contains requirements for control and interlock systems, warning devices and operating procedures for particle accelerators. The subchapter also contains radiation monitoring requirements, ventilation system requirements and standards for electron microscopes.

N.J.A.C. 7:28-21 Analytical X-Ray Installations

This subchapter establishes the safety and operating requirements for the use of analytical X-ray equipment, including but not limited to X-ray diffraction, X-ray spectroscopy, X-ray fluorescence, or fluorescence X-ray spectroscopy equipment. General machine performance standards and facility operating procedures are established as well as additional equipment requirements for open beam and closed beam X-ray systems. The subchapter requires that all analytical X-ray units be registered with the Department. Units must be surveyed before being used for the first time and the survey report submitted to the Department. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-22 and 23 are reserved.

N.J.A.C. 7:28-24 Nuclear Medicine Technology

This subchapter establishes the radiation safety requirements for persons administering radiopharmaceuticals to humans for diagnostic or therapeutic purposes and for performing those diagnostic or therapeutic procedures. This subchapter also establishes the licensing requirements for individuals who administer radionuclides or radiopharmaceuticals while engaged in the practice of nuclear medicine technology. The

criteria for approval of a nuclear medicine technology educational program and curriculum requirements are established in this subchapter. In addition, the examination and licensing fees are set forth in this subchapter. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-25 Radiation Laboratory Fee Schedule

This subchapter establishes the criteria which must be met in order to utilize the State radiation protection laboratory for the purpose of monitoring a public water supply system. This subchapter also sets forth the fees charged by the state radiation protection laboratory to individuals using its services to monitor a public water supply system. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-26 is reserved.

N.J.A.C. 7:28-27 Certification Of Radon Testers And Mitigators

This subchapter was adopted on October 15, 1990 at 22 N.J.R. 3516(a) and was therefore not included in the previous readoption. This subchapter establishes rules, requirements and procedures for becoming a state certified radon testing or mitigation specialist, business or technician in the State of New Jersey. The subchapter prohibits the sale of devices or the testing or mitigation of radon by persons who are not certified under this subchapter and allows for temporary certifications. It requires certified persons to conduct their activities in compliance with the subchapter. The subchapter addresses the application and certification requirements for businesses and individuals who intend to do radon testing or mitigation. Under this subchapter certified radon measurement and mitigation businesses are required to maintain records and submit monthly reports to the Department. The subchapter establishes procedures for renewing certifications and sets forth the conditions for recognizing certifications issued by other states. The subchapter establishes the Department's right to enter and inspect the premises of any applicant or certified radon business. The subchapter describes the conditions under which the Department may deny, suspend or revoke a license. It also notes the criminal penalties for violations of the rules or the Act which were established at N.J.S.A. 26:2D-77. This subchapter establishes the procedures for requesting an adjudicatory hearing when a certification is denied, refused or revoked. The subchapter establishes fees for courses, examinations, certification application review, annual recertification and facility inspections. The subchapter establishes exemptions from certification requirements. It establishes the required elements of a quality assurance plan and the minimum requirements for a radiological safety plan.

N.J.A.C. 7:28-41 Mercury Vapor Lamps

This subchapter establishes safety requirements for the installation and use of a mercury vapor lamp in indoor and outdoor areas which may be occupied by people. This subchapter has not been amended since it was readopted on July 30, 1990.

N.J.A.C. 7:28-42 Radio Frequency Radiation

This subchapter establishes the limits to exposure of individuals to radiofrequency radiation from fixed radio frequency devices which radiate in the frequency range 300 kHz to 100 GHz, including microwave ovens. This subchapter does not apply to the intentional exposure of patients to radiation for the purpose of diagnosis, treatment or the investigation of the prevention or control of diseases. This subchapter has not been amended since it was readopted on July 30, 1990.

Social Impact

There will be a positive social impact from the continuation of these regulations. The proposed readoption of N.J.A.C. 7:28 will ensure the continuation of rules required by the Radiation Protection Act, N.J.S.A. 26:2D-1 et seq. Without these rules, the Department would not have specific standards for protecting the citizens of New Jersey from unsafe practices involving sources of radiation.

Radiation is ubiquitous and in some cases its use is necessary or even desirable. The goal of the radiation protection regulatory program is to prohibit and prevent the use or presence of unnecessary radiation in such a manner as to be, or tend to be, injurious or dangerous to the health of the people, the industrial or agricultural potentials of the State, and the ecology and wildlife of the State. The rules promulgated by the Department and the Commission require that regulated sources of radiation be shielded, transported, handled, used and kept in such a manner as to prevent users and the general public from receiving unnecessary exposures.

Economic Impact

There will be a decrease in the economic impact of these rules due to the elimination of the requirements at N.J.A.C. 7:28-12. Licensees transporting radioactive materials will no longer be required to apply for and obtain a certificate of handling from the State. There was previously no fee charged for issuing the Certificate of Handling; however, there were costs associated with preparing the application, obtaining the certificate and maintaining records associated with the certificate.

There will continue to be an economic impact associated with complying with the rules. Costs of compliance include fees for registration or licensing, expenses for personnel monitoring, costs associated with reporting and recordkeeping and training costs. Since no amendments, other than those discussed above, are being proposed there will be no change in any fees or costs of compliance at this time.

Environmental Impact

The readoption of N.J.A.C. 7:28 will have a positive impact on the environment by ensuring that the standards which prevent or reduce unnecessary radiation exposure will continue in effect.

Regulatory Flexibility Analysis

These rules affect owners, possessors and users of radioactive materials, machine sources of ionizing radiation, sources of nonionizing radiation and individuals and businesses involved in radon measurement and mitigation. The Department estimates that at least 80 percent of those affected meet the definition of "small business" under the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The readoption of these existing rules will not impose any new costs of compliance or fees on small businesses. Costs for licensees who previously had been required to obtain a Certificate of Handling for transporting radioactive materials will decrease.

The fees and compliance costs incurred under the present rules, as discussed in the Economic Impact above, will continue in effect. Under the fees for registrations at N.J.A.C. 7:28-3.12 and the licensing fees at N.J.A.C. 7:28-4.19, fees are based on the type and number of units or the type of licensed activity(ies), respectively. Under this scheme, licensees and registrants with fewer units or less complex licensing needs will pay less in fees. This may or may not correspond with their status as a small business under the Regulatory Flexibility Act. Since fees are based on the number of regulated units and activities and this may or may not correlate with status as a small business, no reduction in fees is provided based upon classification as a small business.

Because the hazard posed by radiation is the same whether the owner of a source of radiation is a small business or not, it is not possible to offer reduced compliance standards for small businesses.

In proposing this readoption, the Department and the Commission have weighed the need to protect the public from unnecessary radiation against the expected economic impact of the rules and has determined that to minimize the standards for small businesses would endanger the environment, public health and safety. Therefore, no exemption from the rules is provided.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 7:28.

Full text of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 7:28-12.

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

7:28-19.5 Proceedings for suspension or revocation

(a) (No change.)

(b) Proceedings against any licensed radiologic technologist under this section shall be instituted by filing with the Board a written charge or charges in the form of a petition under oath against such licensed radiologic technologist.

1. The charges may be [proffered] **preferred** by any person, corporation, association or public officer, or by the Department in the first instance.

2. (No change.)

(c)-(d) (No change.)

(a)

NEW JERSEY LOW-LEVEL RADIOACTIVE WASTE DISPOSAL FACILITY SITING BOARD

Assessment of Generators for the Cost of Siting and Developing a Low-Level Radioactive Waste Disposal Facility

Proposed Amendments: N.J.A.C. 7:60-1.2, 1.3, 1.4 and 1.6

Authorized By: New Jersey Low-Level Radioactive Waste Disposal Facility Siting Board, Paul E. Wyszkowski, Chairman.

Authority: N.J.S.A. 13:1E-177 et seq., specifically 13:1E-181(o)-181.1; N.J.S.A. 32:31-1 et seq.

Proposal Number: PRN 1994-638.

A **public hearing** concerning this proposal will be held on:
Wednesday, January 11, 1995
at 9:30 A.M.
Station Plaza III
First Floor
44 South Clinton Avenue
Trenton, New Jersey

Submit written comments by January 20, 1995, to:
John Weingart, Executive Director
NJ Low-Level Radioactive Waste
Disposal Facility Siting Board
CN 410
Trenton, New Jersey 08625-0410

The agency proposal follows:

Summary

The New Jersey Low-Level Radioactive Waste Disposal Facility Siting Board (Board) is proposing amendments to N.J.A.C. 7:60 which establishes the process for assessing fees to generators and reporting low-level radioactive waste information by generators. N.J.A.C. 7:60 requires New Jersey generators to report low-level radioactive waste information, and to pay for the cost of developing a low-level radioactive waste disposal facility, including the cost of implementing State and Federal laws concerning low-level radioactive waste. This chapter provides for assessment of fees for each fiscal year. A fiscal year covers the period July 1 through June 30.

The Federal Low-Level Radioactive Waste Policy Act of 1980 (P.L. 96-573) (Policy Act) makes each state responsible for providing disposal capacity for low-level radioactive waste generated within its borders. The Federal Low-Level Radioactive Waste Amendments Act of 1985 (P.L. 99-240) (Amendments Act), 42 U.S.C. §§2021b et seq., provides milestones with deadlines and penalties associated with developing new disposal capacity. The Northeast Interstate Low-Level Radioactive Waste Management Compact Act, N.J.S.A. 32:31-1 et seq. (Compact Act) and the Regional Low-Level Radioactive Waste Disposal Facility Siting Act, N.J.S.A. 13:1E-177 et seq. (Siting Act) were enacted in response to Federal law. The Siting Act created the Low-Level Radioactive Waste Disposal Facility Siting Board and gave the Board the responsibility to site and develop a low-level radioactive waste disposal facility in New Jersey. The Radioactive Waste Advisory Committee is generally responsible for advising the Board and the Department of Environmental Protection (DEP) on matters related to low-level radioactive waste, and advising on disposal facility site designation and construction.

The Board is responsible for establishing siting criteria, developing a disposal plan, establishing a siting process, siting and ensuring the construction, operation and closure of the low-level radioactive waste disposal facility, and developing a public information program.

In June 1991, the Siting Act was amended authorizing the Board to 1) require New Jersey generators to report low-level radioactive waste information; 2) oversee construction, operation and closure of a disposal facility; and 3) assess the generators for the cost of developing a low-level radioactive waste disposal facility, and of implementing State and Federal laws concerning low-level radioactive waste. The Board promulgated rules on March 2, 1992 to implement the amendments to the Siting Act by providing a process for assessing the generators through fiscal year 1995 based on generators' use of existing low-level radioactive waste disposal facilities. The process for assessment did not extend beyond fiscal year 1995 so that the Board could evaluate how to account for low-level radioactive waste that is stored instead of disposed. The proposed amendments address assessments from fiscal year 1996 through fiscal year 2001 based on generators' use of low-level radioactive waste disposal facilities and interim storage of low-level radioactive waste now that no disposal facility is currently available to take low-level radioactive waste generated in New Jersey.

The Board recognizes the existence of the unresolved issue of generators who will use the new disposal facility, but have not participated in paying for the development of the facility. The Board intends to evaluate this issue in the future and will consider the feasibility of imposing surcharges on such generators as well as providing credits for those generators who have participated in paying for the development of the disposal facility.

Currently N.J.A.C. 7:60 provides for assessment of fees through Fiscal Year 1995. These assessments are based on the amount of low-level radioactive waste disposed at three commercial disposal facilities located in Nevada, South Carolina and Washington. With the closure of the Nevada and Washington sites on December 31, 1992, and the closure of the South Carolina site on June 30, 1994 to waste generated outside of their compact regions, generators in New Jersey are now temporarily storing low-level radioactive waste until a low-level radioactive waste disposal facility is available to accept New Jersey's low-level radioactive waste.

The proposed amendments provide for assessment of fees through Fiscal Year 2001. These assessments are based on the amount of low-level radioactive waste produced by New Jersey generators, and pending disposal or disposed as low-level radioactive waste at a low-level radioactive waste disposal facility that may become available. The proposed amendments will enable the State to continue to make progress in developing a disposal facility for low-level radioactive waste produced in New Jersey and to implement the requirements of the Policy Act, Amendments Act, Compact Act and Siting Act.

The fee assessment process is expected to provide sufficient revenues from the generators to cover all the costs for the State to site and develop the waste disposal facility, and to implement the Policy Act, the Amendments Act, the Compact Act and the Siting Act. The Board will use the services of qualified contractors, obtained using established State of New Jersey bid procedures, to perform the work of siting, designing, developing, constructing, operating and closing the low-level radioactive waste disposal facility. The Board staff will, among other things, provide support to the Board and Advisory Committee members; oversee progress of the contractors; and coordinate with the DEP, the U.S. Nuclear Regulatory Commission (NRC), the Northeast Compact Commission and other appropriate agencies in the matter of siting, developing, constructing, operating and closing the facility.

The Board is implementing a voluntary approach to site a disposal facility for low-level radioactive waste generated within New Jersey. New Jersey communities will be invited to explore the possibility of hosting such a facility. The Board and interested communities will be working closely and cooperatively to evaluate potential sites. The Board will provide resources to interested communities to participate in the siting process, and provide appropriate protections, compensations and incentives to communities which participate in this process and to the community which hosts the low-level radioactive waste disposal facility.

Activities to be funded by the proposed fees include pre-characterization and site characterization activities necessary to identify a suitable site for development of a low-level radioactive waste disposal facility; public information and participation; assistance grants to municipalities with candidate sites; site suitability studies; statutory adjudicatory hearing and decision making process; legal representation; disposal facility design; preparation and submission of documentation for license and permit applications for operation of a disposal facility; and construction of the disposal facility. The fees will also fund certain support and assistance from the DEP in providing technical assistance to the Board regarding disposal issues and in implementing an interim storage period inspection program, and the Northeast Compact Commission in providing assistance to the Board regarding regional and national disposal issues.

In the proposed amendments of N.J.A.C. 7:60-1.6(e) through (k), the Board is proposing to base the assessment of fees on a formula weighing each generator's use of low-level radioactive waste disposal facilities and use of interim storage, and potential disposal capacity needs for decontamination and decommissioning of nuclear power plant units.

The fees will be calculated principally on the volume and radioactivity of the low-level radioactive waste produced. A generator which produced

greater volume and/or greater radioactivity of waste requiring disposal will be assessed a larger fee than a generator which produced less. The information base for determining volume and radioactivity of waste disposed in a low-level radioactive waste disposal facility will be obtained from the disposal manifests accompanying waste shipments to low-level radioactive waste disposal sites subject to or developed to comply with the Federal Amendments Act as maintained on the National Information Management System operated by the U.S. Department of Energy's National Low-Level Waste Management Program. The information base for determining volume and radioactivity of waste in interim storage pending disposal in a low-level radioactive waste disposal facility will be obtained from reports submitted by generators in compliance with N.J.A.C. 7:60-1.3. Since the Board will be relying on this information base for assessing fees, the proposed amendments to N.J.A.C. 7:60-1.3(a) require each generator to provide the necessary information and to certify that the information provided is true, accurate and complete.

As has been the case, for 93 percent of the assessment budget, the Board will calculate each generator's fee in proportion to its share of the total volume and total activity of all low-level radioactive waste generated in the State. In developing the formula to calculate fees, the Board has chosen to continue using three consecutive years of data rather than one year of data to reduce the influence of year-to-year variability in volume and radioactivity. The use of three years' data also reduces variability in the annual fee calculated for each generator, thus assisting generators' fiscal planning.

As has been the case, the remaining seven percent of the assessment budget will be assessed within the nuclear power plant sector to address the potential need for disposal capacity for decontamination and decommissioning waste.

The Board will use the disposal volume and radioactivity data compiled by the National Information Management System for the years 1991, 1992 and 1993 in calculating fees for the fiscal year 1996 budget. The Board will use years 1992, 1993 and 1994 data in calculating fees for the fiscal year 1997 budget. In this manner, fiscal years 1998 through 2001 will be calculated using the appropriate three years of data. Beginning with year 1994 data, the Board will utilize volume and radioactivity data for low-level radioactive waste disposed in a low-level radioactive waste disposal facility (should such disposal become available and be utilized), and volume and radioactivity data for low-level radioactive waste placed into interim storage (should interim storage be utilized).

In N.J.A.C. 7:60-1.2, the Board is proposing to define "interim storage" as the holding of low-level radioactive waste, by or for a generator, whether on the generator's premises or elsewhere, which is eventually destined for disposal at a low-level radioactive waste disposal facility such as the one which the Board is charged with developing. Interim storage, as defined in the proposed amendments, commences when low-level radioactive waste is initially collected from the individual users of radioactive material. Subsequent to collection, waste may be subjected to some form of treatment, processing or packaging prior to its readiness for shipment to a disposal facility. For example, when low-level radioactive waste that has been placed in a refuse collection container by the user of radioactive materials is collected for storage, commingling, packaging or other treatment or processing, it is considered to be placed into interim storage. The fact that the waste may later be subjected to reduction, solidification, mixing, combining or other forms of treatment, processing or packaging has been provided for by allowing the activity and volume to be counted for reporting purposes no later than March 31 of the following year. To accommodate this, the Board is proposing to amend N.J.A.C. 7:60-1.3(a) so generators must report information by April 30.

In the proposed amendments to N.J.A.C. 7:60-1.2, "SA (YR, G)," "SA (YR, NJ)," "SV (YR, G)" and "SV (YR, NJ)" define terms which are used in the formula for determining a generator's proportionate share of an assessment budget. Low-level radioactive waste that is stored for decay is not considered in interim storage. The proposed amendments N.J.A.C. 7:60-1.2 define the term "store for decay."

By assessing generators based on the quantity of low-level radioactive waste in interim storage, the Board is encouraging generators to process waste by methods such as volume reduction as soon after it enters interim storage as possible. For example, if low-level radioactive waste is produced in New Jersey and placed into interim storage in October 1995 and is volume reduced no later than March 31, 1996, the volume reported of low-level radioactive waste placed into interim storage in 1995 is the reduced volume counted as of March 31, 1996. The generator's assessment for that waste would be based on its reduced volume, not its original volume. On the other hand, if such waste reduction does not take place until March 31, 1996, the volume reported of low-level waste placed into interim storage in 1995 is the unreduced volume counted as of March 31, 1996. This waste would not be counted in the data for 1996 since it was not initially placed into interim storage in 1996.

Also, since at times low-level radioactive waste may be in the custody of someone other than the generator, for example while in transit, processing or storage, etc., the proposed amendments state that waste is considered placed into interim storage for a calendar year whether the waste is physically located on the generator's premises or elsewhere, either at the time it was initially placed into interim storage or at any later time, up to and including March 31 of the following year.

Since July 1994, there has not been a disposal facility available for New Jersey generators to send their low-level radioactive waste. It is, of course, possible that some facility may become available to New Jersey generators prior to the date the facility the Board develops becomes operational. If that were to occur, the Board may reassess a number of its objectives, practices and procedures, including the fee assessment process and procedures. In order to allow the Board to continue normal functioning while any such reassessment takes place, the formula included in the proposed amendments N.J.A.C. 7:60-1.6(f) through (j) combines, for years commencing with 1994, both low-level radioactive waste that is disposed and low-level radioactive waste placed into interim storage during each calendar year. In the proposed amendments N.J.A.C. 7:60-1.2, the terms "DA (YR, G)," "DA (YR, NJ)," "DV (YR, G)" and "DV (YR, NJ)" define the quantity of low-level radioactive waste disposed, as the volume and activity disposed in the year (YR). If waste is initially placed into interim storage in 1995, is volume reduced in 1996, then is disposed of in 1998; it would be included in the data as stored waste in 1995 at the initial volume or reduced volume depending on whether volume reduction occurred by March 31, 1996, and as disposed waste in 1998 at the reduced volume.

The budget for each year will be developed annually. The Board will propose this annual budget, and provide an opportunity for public comment before taking action to approve or modify each year's budget. Notice will be provided in the New Jersey Register and several newspapers with general circulation, at least 30 days prior to the date of the meeting to take action to approve an annual budget, informing the public that the Board will be considering and taking action to adopt an annual budget. The Board will ask for public comment on the budget at this meeting. Once the Board has approved the annual budget, it will be forwarded to the New Jersey Department of Treasury for review and approval pursuant to N.J.S.A. 13:1E-181.3(a).

The Board is proposing an amendment to N.J.A.C. 7:60-1.4(c) incorporating the Board's practice of taking action at a public meeting each year to approve an assessment budget. The assessment budget is the amount of money which will be funded by fees in a given year taking into account surpluses and deficits from the previous year. Notice will be provided in the New Jersey Register and several newspapers with general circulation, at least 30 days prior to the date of the meeting to take action to approve an assessment budget, informing the public that the Board will be considering and taking action to adopt an assessment budget. The Board will ask for public comment on the assessment budget at this meeting.

Once the Board approves the assessment budget for the forthcoming year, the Board proposes to calculate each generator's proportionate share using the methodology described above and set forth in N.J.A.C. 7:60-1.6(a) through (k). The Board will then issue fee assessment notices to the individual generators. The Board will prepare a list of the individual fee assessments for each fiscal year. In addition, an annual audit of expenditures, and of fees collected, will be conducted pursuant to N.J.S.A. 13:1E-181.3(b). The Board is proposing an amendment to N.J.A.C. 7:60-1.4(f) to provide notice of the availability of the assessment budget in addition to the annual budget, the list of fee assessments, and the results of the most recent annual audit. The notice of their availability from the Board will be published in the "New Jersey Register" and several newspapers with general circulation prior to billing the generators.

The Board is proposing minor amendments to the definition of "radioactive waste" in N.J.A.C. 7:60-1.2 which correct grammar and wording.

Social Impact

A positive social impact will result from the proposed amendments to N.J.A.C. 7:60. The proposed amendments to the rules will provide

sufficient funds to carry out responsibilities for low-level radioactive waste under applicable Federal and State laws, including development of a low-level radioactive waste disposal facility.

Since July 1, 1994, generators in New Jersey and many other states have had no access to disposal facilities for low-level radioactive waste. Therefore, waste that is generated in New Jersey and requires disposal must be temporarily stored until there is a disposal facility available. The proposed amendments will also have a positive social impact because it funds DEP inspections during the interim storage period to provide additional oversight related to New Jersey low-level radioactive waste interim storage activities. Quality of life will be improved by the State siting and developing a disposal facility as expeditiously as possible to consolidate and permanently dispose of the low-level radioactive waste generated throughout the State. The development of a disposal facility will make unnecessary prolonged interim storage by generators of low-level radioactive waste, in various locations throughout the State. Generators facing indefinite storage could leave the State or cease or limit operations thus compromising their ability to provide uninterrupted delivery of critical health care services; research, educational and training activities at colleges and universities; and electrical power now benefitting residents of the State.

The proposed amendments will place the financial burden of supporting the siting and development of a low-level radioactive waste disposal facility on those which generate the waste rather than on the general public via General State Funds. A positive social impact is derived because the proposed amendments continue the Board's policy of proportionately assessing the cost to those which generate greater volume or radioactivity of waste, thereby encouraging each generator to reduce the amount of low-level radioactive waste it generates.

Economic Impact

The Board expects that the proposed fees will increase the cost of management of low-level radioactive waste to those which use or possess radioactive materials. In some cases, these costs may ultimately be passed on to consumers.

The fees will cover the costs of implementing a siting process to identify and evaluate sites, and of developing a low-level radioactive waste disposal facility. The fees will cover activities by the Board which are anticipated to include public information and participation, community and local government participation in the siting process, pre-characterization, site characterization, determination of disposal facility technology, selection of a preferred site for facility development, development of environmental and safety analysis reports, submission of permit and license applications, and financial auditing. It is anticipated that community assistance in the form of grants to affected municipalities to cover costs such as site suitability studies and host community benefits, may also be made available with funds derived from the fees.

The fees will also fund certain support and assistance from the DEP in providing technical assistance to the Board regarding disposal issues and in implementing an interim storage period inspection program, and the Northeast Compact Commission in providing assistance to the Board regarding regional and national disposal issues.

The estimated annual budgets (in 1994 dollars) for activities and services to be funded by the fees for fiscal years 1996 through 2001 are shown below. These budgets are illustrative, and the actual budget will include any and all items needed to be completed in order to implement the Policy Act, the Amendments Act, the Compact Act and the Siting Act. A fiscal year covers the period July 1 through June 30. For example, fiscal year 1996 will cover July 1, 1995 through June 30, 1996.

The estimated annual budget for FY-1996 is $10.4 million for activities which are anticipated to include public participation, support to communities to participate in the siting process, site characterization and facility design.

The estimated annual budget for FY-1997 is $12.2 million for activities which are anticipated to include public participation; support to communities to participate in the siting process; and completion of site characterization, Environmental Report and Safety Analysis Report.

The estimated annual budget for FY-1998 is $8.9 million for activities which are anticipated to include public participation, support to communities to participate in the siting process, adjudicatory hearing, submission of permit/license application(s), and responding to regulatory review.

The estimated annual budget for FY-1999 is $12.8 million for activities which include public participation, support to communities to participate in the siting process, and responding to regulatory review of permit/license application(s) to operate a low-level radioactive waste disposal facility.

The estimated annual budget for FY-2000 is $3.9 million for activities which include public participation, support to communities to participate in the siting process and responding to regulatory review of permit/license applications.

The estimated annual budget for FY-2001 is $40.4 million for activities which include public participation, support to communities to participate in the siting process, licensing, land acquisition, preparation of site and first phase of construction.

The following are examples of the calculated fees based on the estimated annual budget for FY-1996 of $10.4 million. If there are no surpluses or deficits then the estimated annual budget would be the estimated fee assessment budget. A generator which produced 1000 cubic feet and five curies annually would pay approximately $149,600. A generator which produced 100 cubic feet and 0.1 curie annually would pay approximately $14,857. A generator which produced 10 cubic feet and 0.001 curie annually would pay approximately $1,483.

	FY-1996 Estimated Annual Budget
Salaries/Fringe (24.25 percent)	$ 684,000
Operating Expenses	$ 336,000
Professional Services (for example, site characterization, facility design, quality assurance, financial audit)	$ 8,125,000
Municipal Assistance Grants	$ 500,000
State's Share for the Northeast Compact Commission as per N.J.S.A. 32:31-1 et seq.	$ 183,000
Support from DEP as per N.J.S.A. 13:1E-177 et seq.	$ 572,000
ANNUAL TOTAL	$10,400,000

	FY-1997 Estimated Annual Budget
Salaries/Fringe	$ 684,000
Operating Expenses	$ 336,000
Professional Services (for example, site characterization, facility licensing, quality assurance, financial audit)	$ 9,681,000
Municipal Assistance Grants	$ 750,000
State's Share for the Northeast Compact Commission as per N.J.S.A. 32:31-1 et seq.	$ 183,000
Support from DEP as per N.J.S.A. 13:1E-177 et seq.	$ 572,000
ANNUAL TOTAL	$12,206,000

	FY-1998 Estimated Annual Budget
Salaries/Fringe	$ 684,000
Operating Expenses	$ 336,000
Professional Services (for example, site characterization, facility licensing, quality assurance, financial audit)	$ 6,364,000
Municipal Assistance Grants	$ 750,000
State's Share for the Northeast Compact Commission as per N.J.S.A. 32:31-1 et seq.	$ 183,000
Support from DEP as per N.J.S.A. 13:1E-177 et seq.	$ 572,000
ANNUAL TOTAL	$ 8,889,000

	FY-1999 Estimated Annual Budget
Salaries/Fringe	$ 684,000
Operating Expenses	$ 336,000
Professional Services (for example, licensing review, quality assurance, financial audit)	$10,313,000
Municipal Assistance Grants	$ 750,000
State's Share for the Northeast Compact Commission as per N.J.S.A. 32:31-1 et seq.	$ 183,000
Support from DEP as per N.J.S.A. 13:1E-177 et seq.	$ 572,000
ANNUAL TOTAL	$12,838,000

	FY-2000 Estimated Annual Budget
Salaries/Fringe	$ 684,000
Operating Expenses	$ 336,000
Professional Services (for example, licensing, site preparation, construction, financial auditing)	$ 1,347,000
Municipal Assistance Grants	$ 750,000
State's Share for the Northeast Compact Commission as per N.J.S.A. 32:31-1 et seq.	$ 183,000
Support from DEP as per N.J.S.A. 13:1E-177 et seq.	$ 572,000
ANNUAL TOTAL	$ 3,872,000

	FY-2001 Estimated Annual Budget
Salaries/Fringe	$ 684,000
Operating Expenses	$ 336,000
Professional Services (for example, licensing, site preparation, construction, financial auditing)	$17,833,000
Site Acquisition	$20,000,000
Municipal Assistance Grants	$ 750,000
State's Share for the Northeast Compact Commission as per N.J.S.A. 32:31-1 et seq.	$ 183,000
Support from DEP as per N.J.S.A. 13:1E-177 et seq.	$ 572,000
ANNUAL TOTAL	$40,358,000
TOTAL	$88,563,000

Environmental Impact

The Board is committed to establishing and implementing a process that will site and develop an environmentally sound facility consistent with the Federal regulations, and the laws and values of the citizens of New Jersey. The proposed amendments will equitably finance a process that will provide a positive environmental impact by developing adequate disposal capacity for low-level radioactive waste generated in New Jersey.

The fees will provide for a detailed and careful process to site and develop a disposal facility which will meet applicable stringent regulatory requirements, and protect public health and safety. When the disposal facility is developed, approximately 700 licensed users of radioactive materials for research and development, electrical power generation, industrial processes and medical care, will be able to dispose of the waste they generate. The development of a disposal facility will make unnecessary the prolonged storage by the generators of low-level radioactive waste in various locations throughout the State. Prolonged storage by individual generators is not as desirable or environmentally effective as a disposal facility will be. Many generators are located in densely populated and developed areas, and did not design their facilities or operations for prolonged storage of low-level radioactive waste. In addition, generators could move or cease operating, compromising their ability to provide long term care of the waste. Government oversight of many storage facilities would be more difficult than overseeing a single disposal facility.

Since fees are proportionately assessed to the amount of waste produced, the proposed amendments will provide another positive environmental impact by providing an incentive for generators to reduce the volume and radioactivity of waste they produce requiring disposal at a low-level radioactive waste disposal facility.

Regulatory Flexibility Analysis

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Board has determined that the proposed amendments will impose no additional reporting, recordkeeping or other compliance requirements on small businesses (as defined in the Regulatory Flexibility Act).

Generally, small businesses generate smaller quantities of low-level radioactive waste. Those generators which produce more waste requiring disposal at a low-level radioactive waste disposal facility should bear the greater share of the costs for siting and developing the low-level radioactive waste disposal facility. Ninety-three percent of the fees is based on the volume and activity of low-level radioactive waste disposed or stored by generators. The remaining seven percent is based on the additional potential need for capacity when nuclear power plants are decommissioned. Based upon recent data, most of the fees will be paid by businesses which are not small since larger businesses generate the majority of the low-level radioactive waste. As an example, for a small generator which generates small quantities of waste (less than 10 cubic feet and less than 0.001 curie, annually), the fee will be less than $1,483 based on an estimated assessment budget of $10.4 million.

In developing the proposed amendments, the Board has balanced the need to protect the environment against the economic impact of the proposed amendments and has determined that to further minimize or eliminate the impact of the amendments on small businesses would endanger the environment, public health and public safety, and, therefore, no exemption from coverage is provided. The Board has determined that the amount of low-level radioactive waste produced by each generator, rather than the size of the business, will provide a sound and fair basis for the fee determination.

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

7:60-1.2 Definitions

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

...

"DA (YR,G)" means the individual generator's (G) annual activity (DA) of low-level radioactive waste produced in New Jersey and disposed in calendar year (YR) in a disposal facility subject to or developed to comply with the Federal Low-Level Radioactive Waste Policy Amendments Act, as compiled from manifests prepared in accordance with U.S. Nuclear Regulatory Commission regulations, standards and guidance, and reported in the U.S. Department of Energy's National Information Management System.

"DA(YR,NJ)" means the sum of all the individual generator's (NJ) annual activity (DA) of low-level radioactive waste produced in New Jersey and disposed in calendar year (YR) in a disposal facility subject to or developed to comply with the Federal Low-Level Radioactive Waste Policy Amendments Act, as compiled from manifests prepared in accordance with U.S. Nuclear Regulatory Commission regulations, standards and guidance, and reported in the U.S. Department of Energy's National Information Management System.

"DEP" means the Department of Environmental Protection.

"Disposal" means the isolation of low-level radioactive waste from the biosphere for the hazardous life of the waste.

"DV(YR,G)" means the individual generator's (G) annual volume (DV) of low-level radioactive waste produced in New Jersey and disposed in calendar year (YR) in a disposal facility subject to or developed to comply with the Federal Low-Level Radioactive Waste Policy Amendments Act, as compiled from manifests prepared in accordance with U.S. Nuclear Regulatory Commission regulations, standards and guidance, and reported in the U.S. Department of Energy's National Information Management System.

"DV(YR,NJ)" means the sum of all the individual generator's (NJ) annual volume (DV) of low-level radioactive waste produced

in New Jersey and disposed in calendar year (YR) in a disposal facility subject to or developed to comply with the Federal Low-Level Radioactive Waste Policy Amendments Act, as compiled from manifests prepared in accordance with U.S. Nuclear Regulatory Commission regulations, standards and guidance, and reported in the U.S. Department of Energy's National Information Management System.

. . .

"Interim storage" means the holding, by or for a generator, whether at the generator's facility or elsewhere, of low-level radioactive waste after initial collection of the waste from the users of radioactive materials, for treatment, processing and/or storage pending disposal at, or pending, during and after, treatment or processing prior to disposal at, a disposal facility subject to or developed to comply with the Federal Low-Level Radioactive Waste Policy Act Amendments.

. . .

"Radioactive waste" means radioactive material which is discarded or intended to be discarded; or is accumulated, stored or physically, chemically or biologically treated prior to, or in lieu of, being discarded; or is applied to the land or placed on the land or contained in product that is applied to or placed on the land in a manner constituting disposal; or has served their intended purpose; or has an expired shelf [line] **life**.

"SA(YR,G)" means the individual generator's (G) annual activity (SA) of low-level radioactive waste produced in New Jersey, placed into interim storage during calendar year (YR) which is processed or in interim storage and counted for reporting purposes no later than March 31 of the following calendar year, as compiled from records maintained in compliance with U.S. Nuclear Regulatory Commission regulations, standards and guidance, and reported under N.J.A.C. 7:60-1.3.

"SA(YR,NJ)" means the sum of all the individual generator's (NJ) annual activity (SA) of low-level radioactive waste produced in New Jersey, placed into interim storage during calendar year (YR) which is processed or in interim storage and counted for reporting purposes no later than March 31 of the following calendar year, as compiled from records maintained in accordance with U.S. Nuclear Regulatory Commission regulations, standards and guidance, and reported under N.J.A.C. 7:60-1.3.

. . .

"Store for decay" or decay in storage means the holding, as authorized by the U.S. Nuclear Regulatory Commission, of waste for a defined period of time, at the end of which the waste is not low-level radioactive waste.

"SV(YR,G)" means the individual generator's (G) annual volume (SV) of low-level radioactive waste produced in New Jersey, placed into interim storage during calendar year (YR) which is processed or in interim storage and counted for reporting purposes no later than March 31 of the following calendar year, as compiled from records maintained in compliance with U.S. Nuclear Regulatory Commission regulations, standards and guidance, and reported under N.J.A.C. 7:60-1.3.

"SV(YR,NJ)" means the sum of all the individual generator's (NJ) annual volume (SV) of low-level radioactive waste produced in New Jersey, placed into interim storage during calendar year (YR) which is processed or in interim storage and counted for reporting purposes no later than March 31 of the following calendar year, as compiled from records maintained in accordance with U.S. Nuclear Regulatory Commission regulations, standards, and guidance, and reported under N.J.A.C. 7:60-1.3.

. . .

7:60-1.3 Reporting requirements for generators

(a) By [March 1] **April 30** of each year, each generator shall provide to the Board **certified** information on the radioactive waste managed by the generator in the preceding calendar year.

1. The certification shall read as follows, Certification Statement: I certify under penalty of law that the information provided in this document is true, accurate and complete. I am aware that there are significant criminal penalties, including fines or imprisonment or both, for submitting false, inaccurate or incomplete information.

2. The certification required by (a)1 above shall be signed by one of the following as appropriate:

i. For a corporation, by a principal executive officer of at least the level of vice president;

ii. For a partnership or sole proprietorship, by a general partner or the proprietor, respectively; or

iii. For a municipality, State, Federal or other public agency, by either the principal executive officer or ranking elected official.

(b)-(d) (No change.)

7:60-1.4 Establishment of annual budget

(a)-(b) (No change.)

(c) In determining the portion of the annual budget which comprises the assessment budget, the Board shall take into consideration any surpluses which can be credited or deficits to be assessed and other available sources of funds. **At a public meeting, the Board shall approve the assessment budget for the next fiscal year. The Board shall provide public notice of the public meeting, in the New Jersey Register and in several newspapers with general circulation, at least 30 days prior to the date of the public meeting. At the public meeting, the Board will take comments on the proposed assessment budget.**

(d)-(e) (No change.)

(f) The Board shall provide public notice of the availability from the Board of the approved budget, **the assessment budget,** the list of fees calculated in accordance with N.J.A.C. 7:60-1.6, and the results of the most recent annual audit, in the New Jersey Register and several newspapers with general circulation before sending out the bills.

7:60-1.6 Fees for generators

(a)-(d) (No change.)

(e) For fiscal year 1996, each generator's base fee shall be calculated using the following formula:

$$\left[\frac{1}{6}\right]\left[\frac{DV(1991,G)}{DV(1991,NJ)} + \frac{DV(1992,G)}{DV(1992,NJ)} + \frac{DV(1993,G)}{DV(1993,NJ)} + \frac{DA(1991,G)}{DA(1991,NJ)} + \frac{DA(1992,G)}{DA(1992,NJ)} + \frac{DA(1993,G)}{DA(1993,NJ)}\right]$$

multiplied by [93% of the Assessment Budget]

(f) For fiscal year 1997, each generator's base fee shall be calculated using the following formula:

$$\left[\frac{1}{6}\right]\left[\frac{DV(1992,G)}{DV(1992,NJ)} + \frac{DV(1993,G)}{DV(1993,NJ)} + \frac{DV(1994,G) + SV(1994,G)}{DV(1994,NJ) + SV(1994,NJ)} + \frac{DA(1992,G)}{DA(1992,NJ)} + \frac{DA(1993,G)}{DA(1993,NJ)} + \frac{DA(1994,G) + SA(1994,G)}{DA(1994,NJ) + SA(1994,NJ)}\right]$$

multiplied by [93% of the Assessment Budget]

(g) For fiscal year 1998, each generator's base fee shall be calculated using the following formula:

$$\left[\frac{1}{6}\right]\left[\frac{DV(1993,G)}{DV(1993,NJ)} + \frac{DV(1994,G) + SV(1994,G)}{DV(1994,NJ) + SV(1994,NJ)} + \frac{DV(1995,G) + SV(1995,G)}{DV(1995,NJ) + SV(1995,NJ)} + \frac{SA(1993,G)}{SA(1993,NJ)} + \frac{DA(1994,G) + SA(1994,G)}{DA(1994,NJ) + SA\ (1994,NJ)} + \frac{DA(1995,G) + SA(1995,G)}{DA(1995,NJ) + SA(1995,NJ)}\right]$$

multiplied by [93% of the Assessment Budget]

(h) For fiscal year 1999, each generator's base fee shall be calculated using the following formula:

$$\left[\frac{1}{6}\right]\left[\frac{DV(1994,G)+SV(1994,G)}{DV(1994,NJ)+SV(1994,NJ)}+\frac{DV(1995,G)+SV(1995,G)}{DV(1995,NJ)+SV(1995,NJ)}+\frac{DV(1996,G)+SV(1996,G)}{DV(1996,NJ)+SV(1996,NJ)}+\frac{DA(1994,G)+SA(1994,G)}{DA(1994,NJ)+SA(1994,NJ)}+\frac{DA(1995,G)+SA(1995,G)}{DA(1995,NJ)+SA\ (1995,NJ)}+\frac{DA(1996,G)+SA(1996,G)}{DA(1996,NJ)+SA(1996,NJ)}\right]$$

multiplied by [93% of the Assessment Budget]

(i) For fiscal year 2000, each generator's base fee shall be calculated using the following formula:

$$\left[\frac{1}{6}\right]\left[\frac{DV(1995,G)+SV(1995,G)}{DV(1995,NJ)+SV(1995,NJ)}+\frac{DV(1996,G)+SV(1996,G)}{DV(1996,NJ)+SV(1996,NJ)}+\frac{DV(1997,G)+SV(1997,G)}{DV(1997,NJ)+SV(1997,NJ)}+\frac{DA(1995,G)+SA(1995,G)}{DA(1995,NJ)+SA(1995,NJ)}+\frac{DA(1996,G)+SA(1996,G)}{DA(1996,NJ)+SA(1996,NJ)}+\frac{DA(1997,G)+SA(1997,G)}{DA(1997,NJ)+SA(1997,NJ)}\right]$$

multiplied by [93% of the Assessment Budget]

(j) For fiscal year 2001, each generator's base fee shall be calculated using the following formula:

$$\left[\frac{1}{6}\right]\left[\frac{DV(1996,G)+SV(1996,G)}{DV(1996,NJ)+SV(1996,NJ)}+\frac{DV(1997,G)+SV(1997,G)}{DV(1997,NJ)+SV(1997,NJ)}+\frac{DV(1998,G)+SV(1998,G)}{DV(1998,NJ)+SV(1998,NJ)}+\frac{DA(1996,G)+SA(1996,G)}{DA(1996,NJ)+SA(1996,NJ)}+\frac{DA(1997,G)+SA(1997,G)}{DA(1997,NJ)+SA(1997,NJ)}+\frac{DA(1998,G)+SA(1998,G)}{DA(1998,NJ)+SA(1998,NJ)}\right]$$

multiplied by [93% of the Assessment Budget]

[(e)](k) (No change in text.)

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS LEGALIZED GAMES OF CHANCE CONTROL COMMISSION

Amusement Games
Maximum Fee for Participation in Game
Reproposed Amendment: N.J.A.C. 13:3-3.4

Authorized By: Legalized Games of Chance Control Commission, William J. Yorke, Executive Director.
Authority: N.J.S.A. 5:8-79.
Proposal Number: PRN 1994-660.

The Commission will conduct **a public hearing** on Monday, January 9, 1995 between the hours of 1:00 P.M. and 4:00 P.M. at 31 Clinton Street, 2nd Floor, Newark, New Jersey. Persons wishing to speak at the hearing should submit a brief synopsis of the proposed statement or identify the topic about which they will speak so that the Commission may determine the sequence and identify of speakers who will provide it with relevant non-cumulative comments and data.

Submit written comments by January 18, 1995 to:

William J. Yorke, Executive Officer
Legalized Games of Chance Control Commission
Post Office Box 46000
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Amusement Games Licensing Law authorizes the playing of games of chance, skill or a combination of both for amusement or entertainment, at seashore and other resorts, amusement parks, and agricultural fairs provided the prizes awarded consist only of merchandise. The Control Commission previously proposed an amendment to N.J.A.C. 13:3-3.4 to allow an amusement game operator to charge a player a maximum of $3.00 for an opportunity to play a game operated under a license issued pursuant to the Amusement Games Licensing Law (see 26 N.J.R. 1297(a).) A public hearing was held according to law, on April 13, 1994 regarding this matter. Several representatives of the amusement games industry appeared in support of the proposal. Administratiave Law Judge Thomas Clancy served as hearing officer, and made no recommendations. The hearing record may be reviewed by contacting William J. Yorke, Executive Officer, Legalized Games of Chance Control Commission, P.O. Box 46000, Newark, NJ 07101. The Commission which has had jurisdiction over amusement games since February 1993, determined that it needed additional time to study the effects of the proposal and postponed action until after the summer season.

On September 14, 1994 the Commission met and after careful consideration of all comments received and a report on the activities conducted under the 1,000 plus licenses issued declined to adopt the outstanding proposed amendment finding that a charge of $3.00 did not appear warranted. At that time the Commission voted to make this reproposal. This reproposed amendment differs from the previous one in that it reduces the maximum allowable fee to be charged for participation in a game operated under a license issued pursuant to the Amusement Games Licensing Law from $3.00 to $2.00. By setting the fee at $2.00 this amendment is responsive to the request from the New Jersey Amusement Association for an increase in the maximum allowable charge for participation in an amusement game, and still maintains the essential element of family amusement and entertainment. The Association requested an increase in the maximum fee that a licensed amusement game operator may charge a player for a single opportunity to play an amusement game and also the maximum fee that a licensed amusement game operator may charge a player for the opportunity to play an amusement game several times. In considering the request, the Commission finds that the provisions of N.J.A.C. 13:3-3.4, which allow licensees to charge as much as $5.00 for multiple opportunities to play subsequent amusement games, are in conflict with the Amusement Games Licensing Law, specifically N.J.S.A. 5:8-107, which states in pertinent part "... all winners shall be determined and all prizes shall be awarded in any game forthwith upon the completion of the game and before making or accepting any charge for participation in any subsequent game." The proposed amendments to N.J.A.C. 13:3-3.4 will raise the maximum fee for player participation in an amusement game, but will eliminate the provisions which appear to authorize the making or accepting of a charge for entry into a subsequent game prior to the completion of an initial game.

The Commission, while clarifying the inability of a licensee to charge for or collect a fee for participation in subsequent games, has authorized its licensees to discount the fee for entry into a single game if they so desire. For example, if the fee to enter a single amusement game is $1.00, the operator may permit three opportunities to play in that single game for $2.00. The operator may not charge or accept $2.00 and permit the player to participate in a second or subsequent game. The game must be completed prior to the operator making or accepting a charge to participate in a subsequent game. A game is completed when a wager is placed, the occurrence that determines the winner transpires, and the prize is awarded.

N.J.S.A. 5:8-107 provides that the Commission shall, after public hearing, and in accordance with the provisions of the law, determine the amount a licensee may charge or accept from any person for participation in an amusement game. The maximum fee a licensee may charge or accept from a player has not increased since 1983, except for the fee to play arcade games which was raised from $0.50 to $1.25 provided the game afforded the player an enhanced form of play. Licensees report that since the last increases, costs such as the lease or maintenance of amusement game sites, purchase of merchandise awarded as prizes to players, labor and other business related expenses have contributed to a significant decrease in profit derived from the operation of an amusement game business. It is necessary to establish a charge to play amusement games that is economically attractive to the player and satisfying to the licensed operator. Licensees should be allowed sufficient flexibility in the fee structure to enable them to charge entry fees appropriate to the type of game operated and economic conditions. Licensees contend that limits on allowable entry fees presently in place do not afford that opportunity nor are they indicative of the current market.

This proposal will impose a reasonable limitation on fees charged to players, ensure that charges are made in a manner consistent with the law, and allow operators flexibility to react to market trends and economic conditions.

Social Impact

The Amusement Games Licensing Law authorizes the operation and regulation of amusement games which provide amusement and entertainment and award merchandise prizes to players visiting sea shore and other resorts, amusement parks and agricultural exhibitions. This proposed amendment gives licensees needed flexibility to adjust the price to play amusement games consistent with market conditions, while at the same time placing a reasonable limit on the maximum fee to be charged. It is expected that the amendment will have a positive social impact.

Economic Impact

In 1994, 1,008 licenses to operate amusement games were issued. The amusement games operated pursuant to those licenses are one of the many attractions of the New Jersey shore resorts and a traditional activity at the amusement parks and agricultural exhibitions (county fairs) located throughout the state. Amusement games are operated for the most part for commercial purposes offering summer employment to students and others available during the traditional season of operation. Licensees are required to make significant investment in both property and equipment. Allowing an increase in the maximum price for participation in a game is expected to afford the licensee the opportunity to introduce a greater variety of prizes and new and exciting games. Persons visiting the locations where amusement games are played are free to choose to play or not to play the games. Those who do play will weigh the price to play against the prize offered. In most cases, this interaction in the market place will prevent licensees from charging prices for entry into a particular game which are disproportionate to the value of the amusement, entertainment or the prize offered. The Commission is statutorily mandated to set the maximum charge to be made or accepted by any licensee. These controls are in the best interest of the public and the industry. The maximum charge set by this proposal will provide licensees with an opportunity to earn a reasonable profit and at the same time protect the public from excessive charges thus providing a positive economic impact.

Regulatory Flexibility Analysis

The proposed amendment to N.J.A.C. 13:3-3.4 focuses on raising the maximum fees that amsuement games licensees may charge players. The amendment does not impose any additional administrative burden on the amusement games industry in terms of reporting and recordkeeping requirements, initial capital costs, costs for employing professional services, or other costs of compliance.

The increased fees to participate in amusement games will be imposed only on those members of the public who choose to play the games. The increase in fees will not necessarily result in greater cost to the public. The amendment will adjust the price to play amusement games to reflect current market conditions. The proposed fees will offer licensees an opportunity to adjust their prices within limits, in response to economic conditions and market trends.

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

13:3-3.4 Maximum fee for participation in game

(a) [Except as set forth in this section, no] **No** licensee shall charge or accept, or allow[,] **or** permit [or suffer], directly or indirectly, the charging or accepting of more than [$1.00] **$2.00** from any one player [or participant] **for an opportunity to participate** in any one amusement game [for each single or multiple entry fee or payment for the privilege of participating in the game].

(b) All prizes or tickets or tokens redeemable for a prize awarded in a game shall be awarded immediately upon completion of the game and before making or accepting a charge for participation in any subsequent game.

(c) No charge may be made or accepted for participation in a game in excess of the posted charge for the opportunity to participate in the game. Nothing in this section shall be construed to prohibit a licensee from offering a discounted entry fee for multiple opportunities to participate in a single game not in excess of $2.00. [The maximum charge for participation in any skill game certified in N.J.A.C. 13:3-7.9(a)1 under Certification No. 1 shall not exceed $1.00 for any one game or play, except that a charge not to exceed $2.00 may be made for multiple plays, the aggregate number of which must be greater than the sum of the plays available at the single play price.

(c) The maximum charge for participation in any game of chance certified in N.J.A.C. 13:3-7.9(a) or (a)9 under certifications No. 5 or No. 9 shall not exceed $1.00 for any one game or play, except that a charge not to exceed $2.00 may be made for multiple chances, the aggregate number of which must be greater than the sum of the chances available at the single play price.

(d) The maximum charge for participation in any arcade game certified in N.J.A.C. 13:3-7.9(a)2 under Certification No. 2 shall not exceed the maximum charge specified in the original or amended certification, but in no event shall the amount exceed $1.00, except that where a machine or device permits an enhanced mode of play the total shall not exceed $1.25. Dollar bill acceptors may be used only where the certification allows a charge of $1.00 for a single play. Dollar bill acceptors, if used shall not accept more than one bill for a single play and in no event shall the machine accept multiple bills for credit or multiple play build up. Bill acceptors shall not accept bills larger than a $1.00 denomination. The maximum denomination currency for games permitting an enhanced mode of play shall not exceed $0.25, with a cumulative total of $1.25, when the maximum number of coins are inserted. The number of tickets or tokens awarded shall be at least proportionately increased when additional coins are inserted. In establishing the maximum charge for an arcade machine or device, the Commissioner shall consider, but is not limited to, the following:

1. The type and nature of the machine or device;
2. The type of prize it is designed to award;
3. The number and denomination of currency required or permitted for play; and
4. The time required to complete a game or play.

(e) The maximum charge for participation in any group game certified in N.J.A.C. 13:3-7.9(a)4 under certification No. 4 shall not exceed $1.00 for any one game or play, except that an increased charge not to exceed $5.00 may be made to allow play for a set period of time, provided that the number of games to be played within that period of time shall exceed the number of games or plays that would be played at the single game or play price.

(f)](d) Upon receipt of currency greater than the charge [for the game or play] **to play a game**, the licensee must immediately remit the appropriate change to the player.

(a)

DIVISION OF CONSUMER AFFAIRS
NEW JERSEY STATE BOARD OF ARCHITECTS
Board of Architects Rules
Proposed Repeal and New Rules: N.J.A.C. 13:27

Authorized By: State Board of Architects, James S. Hsu, Executive Director.

Authority: N.J.S.A. 45:3-3 and 7 and 45:1-3.2.

Proposal Number: PRN 1994-654.

Submit written comments by January 18, 1995 to:

James S. Hsu, Executive Director
State Board of Architects
Post Office Box 45001
Newark, New Jersey 07101

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 13:27 is scheduled to expire on February 20, 1995. The New Jersey State Board of Architects has reviewed its existing rules and has deemed them to be in need of reorganization, clarification, refinement and updating so comprehensive in nature as to necessitate the repeal of N.J.A.C. 13:27 and the proposal of a new set of rules. The proposal reclassifies existing provisions into

appropriate groups and clarifies language to remove inconsistencies. Except as noted specifically below, the rules are not materially different from their counterparts in the Board's existing body of rules.

Subchapters 1 and 2 set forth the purpose and scope of the proposed rules and describe the administration of the Board.

Subchapter 3 addresses architectural practice and responsibility. N.J.A.C. 13:27-3.1 sets forth definitions of key words and terms used in the Board's rules. The following new definitions are proposed for clarification or for the reasons otherwise noted: "certificate of authorization"; "certificate of registration or license" (to clarify that these two terms are interchangeable and synonymous); "construction documents" (replaces the traditional terms "plans" and "specifications" for consistency with State Uniform Construction Code terminology); "diversified experience in architecture"; "office of a registered architect in private practice" (reflects specific changes regarding the training and experience required for examination candidates); and "principal."

N.J.A.C. 13:27-3.2 sets forth the scope of architectural services and permissible advertising practices. N.J.A.C. 13:27-3.3 provides an exemption from the rules in this chapter for an individual who designs a single family dwelling to be constructed solely as his or her residence or the residence of a family member. N.J.A.C. 13:27-3.4 limits and defines those instances in which impersonal names may be used. These provisions substantially revise those previously set forth at N.J.A.C. 13:27-4.12. Subsections (b) and (c) clarify that impersonal names may be used only by professional service corporations and general business corporations. The new provisions are consistent with statutory requirements for both types of business entities.

N.J.A.C. 13:27-3.5(a) and (b) place restrictions on the use of titles. New portions of subsection (c) exempt organizations established as professional service corporations and general business corporations from restrictions requiring such organizations to change the name of the entity upon the death of a partner or shareholder.

N.J.A.C. 13:27-3.6 sets forth requirements regarding notification of change of address and service of process.

Subchapter 4 sets forth licensing procedures. N.J.A.C. 13:27-4.1 tracks N.J.S.A. 45:1-21 and 45:3-5, so as to provide candidates for licensure with a condensed, readily accessible version of the statutory licensing requirements. New regulations at N.J.A.C. 13:27-4.2 describe Board procedures for the review and evaluation of foreign degrees. Evaluation costs must be borne by the applicant.

A major change is proposed in connection with training requirements, which appear at N.J.A.C. 13:27-4.3 through 4.7. Under N.J.A.C. 13:27-4.7, after January 1, 1998, all applicants must be certified by the Intern Development Program (IDP) of the National Council of Architect Registration Board (NCARB). New Jersey, which is one of 55 member boards of NCARB, currently treats IDP as optional for applicants for registration. The 1998 deadline will permit sufficient lead time for candidates to enroll in the three-year IDP program.

N.J.A.C. 13:27-4.3 sets forth educational prerequisites to commencement of training. N.J.A.C. 13:27-4.4 through 4.6 describe training requirements during the transition period leading up to the mandatory IDP on January 1, 1998. During the transition period, the Board will accept either IDP certification or training consistent with these sections. Consistent with IDP standards, training during this period must include training in the office of a registered architect in private practice. This requirement will ensure that applicants for registration have developed their skills in architect-client relationships and have had exposure to the operation of an architectural practice. The applicant may request Board approval to train in other settings. Consistent with NCARB/IDP standards, training in an interior designing setting will no longer be acceptable.

N.J.A.C. 13:27-4.5 addresses intern training centers in public and private non-profit institutions, so as to ensure that there is sufficient diversity and scope to the training provided. Applicants are required to submit documentation prior to such training in order to ensure that the training provided is competent, adequate and diverse. Internship programs in private non-profit institutions, while under the supervision of a registered architect, have been added to this section.

N.J.A.C. 13:27-4.6 prescribes the review process for candidates working for private corporations when under the supervision of a registered architect.

N.J.A.C. 13:27-4.8 identifies the subjects covered by the qualifying examination. A new examination section has been included—Division A, pre-design—that professional engineers, pusuant to new N.J.A.C. 13:27-4.9, will be required to pass. The Board has determined that this section of the examination deals with critical parts of the design process.

N.J.A.C. 13:27-4.10, Registration by reciprocity, has been updated to reflect current practice, removing the requirement that a candidate with a deficiency in either experience or education had to sign and seal plans in his or her base jurisdiction for at least five years in order to demonstrate "responsible practice." That requirement was deemed to be unduly restrictive, particularly as applied to a fledgling architect. As revised, this subsection conforms to N.J.S.A. 45:3-6.

The Board's fee schedule is codified at N.J.A.C. 13:27-4.11.

Subchapter 5 sets forth rules of professional practice previously codified at subchapter 9. New provisions include the following: Pursuant to N.J.A.C. 13:27-5.2, a licensee must cooperate with any official request for information from the Board so as to facilitate licensure applications and Board investigations. N.J.A.C. 13:27-5.3 requires the architect to enter into a contract directly with a client instead of permitting his or her services to be offered through an intermediary such as a contractor, in violation of N.J.S.A. 45:3-17. This provision will give the Board a sounder basis to establish accountability and responsibility in the context of consumer complaints and disciplinary proceedings.

N.J.A.C. 13:27-5.5, Professional practice and procedures, recodifies existing N.J.A.C. 13:27-9.4, though with a new title and other changes as follows. Subsection (a) ensures that each office will have an architect in responsible charge. Subsections (b) and (c) make explicit that "plan-stamping" is impermissible in accordance with the Board's disciplinary history regarding that ploy.

Subchapter 6 regulates the issuance of certificates and seals and the information required to appear in the title block. The requirement that all steps in the licensure application process be fulfilled within 90 days of when the fees were paid is no longer required. Applicants will retain the choice as to when and whether to complete the application process without risk of financial penalty, although they will still not be considered to be licensed until all pertinent fees have been paid.

N.J.A.C. 13:27-6.2 tracks N.J.S.A. 45:3-21 and reiterates in regulatory form policy guidelines regarding renewal procedures.

N.J.A.C. 13:27-6.3 clarifies reinstatement procedures. In some instances, applicants for reinstatement will be required to demonstrate professional competence.

N.J.A.C. 13:27-6.4 sets forth requirements concerning an architect's seal press. New subsection (d) permits the family of a deceased licensee to retain the architect's seal press as a memento.

N.J.A.C. 13:27-6.5 outlines requirements for signing and sealing documents. The section makes references to a "tracing" in order to reflect this new term of art and utilizes the phrase "in responsible charge" so as to define who within the practice shall bear responsibility for the signing of documents. Subsection (a) provides for the alternative that the personal signature of the architect may be affixed to each copy of each drawing. Subsection (b) is proposed in order to ensure that changes made to construction drawings will be approved by the architect in charge.

N.J.A.C. 13:27-6.6 through 6.8 set forth title block requirements and contain the following new provisions. Allied professionals must be identified in the title block in order to ensure complete and accurate information; a secondary title block must be provided when the architect is a subcontractor on an engineering project so as to be in compliance with the Building Design Services Act of 1989; and an architect practicing in a business setting must provide a secondary title block identifying the business entity as the "owner" in order to ensure complete information.

Subchapter 7 identifies the permissible division of responsibility in connection with the submission of site plans and major subdivision plats.

Subchapter 8 pertains to landscape architects and includes requirements for initial certification and renewal; continuing education; and rules of conduct. Changes have been made in existing regulations by removing sections that are no longer applicable and clarifying the requirements for approval of continuing education courses.

Specifically, N.J.A.C. 13:27-8.5 provides a more complete explanation of the material included in the New Jersey law section of the Landscape Architect Registration Examination.

N.J.A.C. 13:27-8.6 sets forth requirements for certification of individuals who are certified in another state. New provisions have been added to give the Committee more flexibility in granting certification to candidates whose pre-certification education or experience has been deemed deficient. These individuals may qualify in New Jersey by demonstrating five years of experience in landscape architecture subsequent to licensure or certification.

N.J.A.C. 13:27-8.7, Initial certification and renewals, removes existing provisions that pro-rate registration fees by months, consistent with most

other professional licensing boards which prorate fees on a yearly basis. N.J.A.C. 13:27-8.8 will permit the issuance of duplicate certificates, since the Board recognizes that a landscape architect may be employed in several locations. N.J.A.C. 13:27-8.9 sets forth seal press and title block requirements for the certified landscape architect.

N.J.A.C. 13:27-8.10 and 8.11 specify that 30 continuing education credits are required as a condition of certification renewal and that 15 credits may be carried over into the next biennial period. N.J.A.C. 13:27-8.12 identifies the acceptable sources and topics for continuing education purposes. N.J.A.C. 13:27-8.13 describes how continuing education credits are calculated, and defines limitations in credit hours permitted for such activities as writing in professional journals, graduate work, teaching or research.

N.J.A.C. 13:27-8.14 defines the filing and reporting requirements to coincide with biennial registration. N.J.A.C. 13:27-8.15 identifies grounds for the Committee to exercise discretion in granting waivers from the continuing education requirement for reasons of hardship or disability.

N.J.A.C. 13:27-8.16 prescribes the responsibilities of continuing education program sponsors, including procedures for Committee approval. N.J.A.C. 13:27-8.17 deals with continuing education credit by endorsement, and N.J.A.C. 13:27-8.18 prescribes procedures for the Committee to verify for another State that a New Jersey certificate holder has completed continuing education requirements.

N.J.A.C. 13:27-8.19 contains "Rules of Professional Conduct." N.J.A.C. 13:27-8.20, Nomenclature for non-certified persons, eliminates existing examples of acceptable and unacceptable terminology for certified and non-certified persons. These terms were determined to be incomplete. New language contains a more definitive statement prohibiting a non-certified individual to use the terms "landscape architect" or "landscape architecture" in any advertisement or offer of services. N.J.A.C. 13:27-8.21 sets forth landscape architect certification fees, and N.J.A.C. 13:27-8.22 concerns address changes.

Social Impact

The proposed new rules recodify and clarify existing regulations, provide codifications of accepted standards of practice and update precepts long embodied in the curent rules. In so doing, the rules address many questions submitted to the Board by licensees, candidates for licensure and the public concerning existing rules and standards of practice. Licensees will benefit from the new rules in that they will have a clear and comprehensive set of regulations to guide them in their professional practice.

The overall impact of the new rules on the public is expected to be advantageous because the rules enhance consumer information and protection. As updated, the rules will continue to ensure that only truly qualified individuals are licensed to practice in this State and that high levels of professionalism are maintained. Furthermore, the new rules embody provisions that will resolve ambiguities and, in general, clarify the responsibilities of licensees to the public.

More specifically, the revisions require that candidates for licensure receive diversified architectural training; that persons with an engineering background are competent in the building design process; and that the architect in responsible charge of a general business corporation will be readily identifiable and accessible for legal purposes.

In addition, N.J.A.C. 13:27-4.4 will benefit the public by permitting the Board discretion and flexibility in approving candidates for admission by reciprocity, thereby enlarging the pool of qualified architects available to provide architectural services.

Revisions to N.J.A.C. 13:27-5.2(c) will also benefit the public, by setting forth standards regarding false statements and the failure of licensees to disclose facts to the Board. These revisions are expected to create a higher standard of compliance that will result in better information being available to the Board to protect the public's interests.

N.J.A.C. 13:27-5.3(a) will benefit the public by enhancing the licensee's obligation to structure business relations that ensure a direct line of responsibility between the architect and client. The requirement to exercise "... independent, unprejudiced judgement ..." is designed to ensure the integrity of the architectural process.

N.J.A.C. 13:27-5.5(b) and (c) will benefit the public through the addition of explicit terminology that addresses the aiding and abetting of unlicensed practice. This is expected to facilitate the prosecution of the practice commonly known as "plan-stamping."

N.J.A.C. 13:27-8.8, concerning candidates for certification from another jurisdiction, will benefit these candidates by providing a means to correct deficiencies in experience or education in order to become certified in this State.

Economic Impact

The rules in this chapter will have an economic impact upon applicants for licensure, licensees, applicants for certification, and certified landscape architects, who must pay the examination, application and biennial renewal fees identified in the proposed fee schedules and who are expected to spend what is necessary to maintain their practices in the manner prescribed by the Board.

Additional fees may be incurred by either an architect or a landscape architect for filing a change of address, requesting a replacement seal press or certificate and reinstating a lapsed license or certificate. Issuance of a duplicate certificate may be made only upon the presentation of an affidavit to the Board. Licensees and certificate holders who must notify the Board of an address change will incur the costs of sending the notice by certified mail.

Certified landscape architects will incur the costs necessary to complete 30 hours of continuing education as a condition of biennial license renewal. The Board cannot estimate the cost to the landscape architect in obtaining such credits, as program sponsors charge varying fees. A program sponsor who wishes to obtain Board approval will incur costs associated with complying with N.J.A.C. 13:27-8.16, including providing documentation to the Board for evaluation and soliciting course evaluations from both participants and instructors.

Furthermore, the proposed changes to the existing regulations will have the following economic impact:

N.J.A.C. 13:27-4.2 will have a beneficial economic impact on examination candidates for licensure by establishing a flexible interpretation of necessary qualifying experience. By distinguishing between acceptable and unacceptable training settings, this provision will enable candidates to avoid investing time and effort in employmet settings that do not qualify a candidate for licensure.

N.J.A.C. 13:27-4.3 will have an economic impact on a limited number of professional engineers who wish to be eligible to become licensed architects. Those candidates will now be required to successfully complete the "Pre-Design" section of the Architect Registration Examination, at a cost estimated to be approximately $100.00 per administration.

N.J.A.C. 13:27-4.4 will have a beneficial economic impact on candidates for admission by reciprocity, who were previously subject to requirements that may have entailed a greater cost.

Subchapter 8 is expected to benefit certificate holders by providing greater flexibility in the completion of continuing education requirements at less cost.

The Board believes the economic impact upon applicants, licensees and certificate holders is outweighed by the benefits these rules provide in maintaining professional practice standards that serve to protect the public safety. The Board notes that no increases are being proposed to the existing fee schedules. Because funding of the Board's operation is attained by the proposed fee structure, failure to adopt it would place the Board's operations in jeopardy.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., architects and landscape architects are deemed "small businesses," then within the meaning of the statute the following statements are applicable.

The Board of Architects currently has approximately 7,000 licensees. The proposed new rules contain reporting, recordkeeping, and compliance requirements as follows. The Board does not anticipate that compliance will occasion initial capital costs or costs for professional services.

Architects and landscape architects must comply with all practice standards contained in this chapter with regard to the offering of professional services, including those with regard to signing and sealing documents and advertising.

An architect must report to the appropriate public official any unlawful decision taken by his or her client or employer against the architect's advice; make certain disclosures to a prospective or existing client regarding his or her qualifications and scope of responsibilities; and report address changes within 30 days of the change. Landscape architects must verify on their renewal applications that they have completed 30 hours of prescribed continuing education courses.

Because these rules seek to promote and protect the public's health, safety and welfare through regulation of architects and landscape architects, no differentiation in compliance based upon business size is provided.

Full text of the repeal may be found in the New Jersey Administrative Code at N.J.A.C. 13:27.

Full text of the proposed new rules follows:

CHAPTER 27
NEW JERSEY STATE BOARD OF ARCHITECTS

SUBCHAPTER 1. PURPOSE AND SCOPE

13:27-1.1 Purpose

These rules define and establish guidelines for the practice of architecture in the State of New Jersey.

13:27-1.2 Scope

The practice of architecture is regulated by P.L. 1902, c.29, p. 54 as amended and supplemented (N.J.S.A. 45:3-1 et seq.) and by rules adopted in accordance with the New Jersey Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.).

SUBCHAPTER 2. ADMINISTRATION

13:27-2.1 Establishing Board name

In accordance with P.L. 1902, c.29, p. 54 as amended and supplemented (N.J.S.A. 45:3-1 et seq) the name of this Board shall be the New Jersey State Board of Architects.

13:27-2.2 Office location

The offices of the Board are located at 124 Halsey Street, PO Box 45001, Newark, New Jersey 07101.

13:27-2.3 Meetings of board; quorum

(a) The Board shall hold an annual meeting at the Board office in July of each year.

(b) The meetings of the Board shall be held as scheduled and notice thereof shall be filed in accordance with the Open Public Meetings Act (P.L. 1975, c.231).

(c) A majority of the appointed membership of the Board shall constitute a quorum (N.J.S.A. 45:1-2.2(d)).

(d) Chronic absence and/or lack of participation by a member in Board activities, as documented by Board records, may be the basis for the submission of a request for replacement to the appropriate authority, as determined by a majority vote of the Board.

13:27-2.4 Election of officers; term; vacancies

(a) At its annual meeting, the Board shall elect from its members a President and a Vice President. These officers shall be elected by a quorum of the Board.

(b) The term of each officer so elected shall be for one year, but shall continue until a successor has been elected and qualified, unless such officer is removed for cause by vote of a quorum of the Board. In the event of a vacancy in an office, an officer shall be elected by a quorum of the Board to fill the unexpired term.

13:27-2.5 Duties of officers: committee appointments

(a) The President of the Board shall preside at all meetings, appoint all committees and chairpersons and shall perform all other duties ordinarily pertaining to the Office of the President or as may be directed by the Board.

(b) The Vice President shall perform the duties of the President during the absence or incapacity of the President. In the absence of both the President and Vice President, the Board member with seniority shall preside.

13:27-2.6 Executive Director; duties

(a) An Executive Director shall serve as chief administrative officer and official custodian of the records of the Board.

(b) The Executive Director shall, in a thorough and efficient manner, fulfill administrative duties, including, but not limited to, duties in connection with the keeping of minutes of meetings, examinations, correspondence, staff and records.

13:27-2.7 Roster; dissemination of statutes, rules and code data

A roster of architects and landscape architects registered in the State of New Jersey shall be issued every two years. The roster shall also include the laws and regulations pertaining to the practice of architecture and landscape architecture and shall list other appropriate codes relating to the practice of architecture and landscape architecture in New Jersey.

SUBCHAPTER 3. ARCHITECTURAL PRACTICE AND RESPONSIBILITY

13:27-3.1 Definitions

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

"Advertisement" means any communication to the public including, but not limited to, newspaper, periodical, journal, flyer, business card, radio, telephonic or television communication in which architectural services are offered or by which the availability of architectural services is made known.

"Advertiser" means a person offering architectural services in the State of New Jersey by way of an advertisement.

"Aesthetic principles" means the concepts of order, balance, proportion, scale, rhythm, color, texture, mass and form as used in the design process.

"Architect" means an individual who through education, training, and experience is skilled in the art and science of building design and has been licensed or registered by the New Jersey State Board of Architects to practice architecture in the State of New Jersey.

"Architectural services" or "practice of architecture" means the rendering of any of the following services in connection with the design, construction, enlargement, or alteration of a building or a group of buildings and the space within or surrounding those buildings, which have as their principal purpose human use or habitation. These services include site planning, providing preliminary studies, architectural designs, drawings, specifications, other technical documentation, and construction supervision for the purpose of determining compliance with construction documents.

"Architecture" means the art and science of building design and particularly the design of any structure for human use or habitation. Architecture, further, is the art of applying human values and aesthetic principals to the science and technology of building methods, materials and engineering systems as required to comprise a total building project with a coherent and comprehensive unit of structure and site.

"Board" means the New Jersey State Board of Architects.

"Certificate of authorization" means a certificate issued by the Board to a general business corporation to permit the practice of architecture pursuant to N.J.S.A. 45:3-18.

"Certificate of Registration" or "license" means official documents attesting to the fact that the individual has met the minimum requirements to practice architecture in the State of New Jersey. For the purposes of this chapter, the terms "licensed" and "registered" are used interchangeably.

"Closely allied professional" means and is limited to licensed architects, professional engineers, land surveyors, and professional planners.

"Construction documents" means all of the written, graphic, and pictorial documents prepared or assembled for describing the design, location and physical characteristics of the elements of a construction project.

"Design services," as provided by a builder or home improvement contractor, means conceptual drawings or sketches of floor plans or elevations and the rendering of price quotations or estimates all of which may be necessary to develop the scope, character and potential cost of a one or two-family, detached home or improvement thereto.

"Diversified experience in architecture" means a wide spectrum of professional experience consistent with the elements defined by the National Council of Architecture Registration Boards (NCARB) through its Intern Development Program (IDP).

"Human use or habitation" means the activities of living, including, but not limited to, fulfilling domestic, religious, education, recreational, employment, assembly, health care, institutional, memorial, financial, commercial, industrial and governmental needs.

"Human values" means the social, cultural, historical, economic and environmental influences that have an impact on the quality of life.

"Office of a registered architect in private practice" means an organization which offers architectural service, is in the responsible charge of a registered architect(s) who is/are the principal owner or owners of the organization, and has no affiliate engaged in construction activities.

"Organization or affiliate 'engaged' in construction" means one which: undertakes to provide labor and/or material for all or any portion of a construction project, whether on lump sum, cost plus or other basis of compensation; and agrees to guarantee to a property owner the maximum construction cost for all or any significant portion of a construction project.

"Person" means any individual or any business associations or entity.

"Principal" means a registered architect who is an owner in whole or in part of any business entity authorized by law to offer or render architectural services.

"Responsible charge" means the rendering of regular and effective supervision by a competent licensed architect to those individuals performing services which directly and materially affect the quality and competence of architectural services rendered by the licensee.

13:27-3.2 Scope of architectural service; advertising

(a) No person, except an architect licensed in the State of New Jersey, shall use the title "architect" or its substantial equivalent or otherwise represent to the public that the person is licensed to practice architecture in this State.

(b) No advertisement shall include the terms "architect," "architectural," "architect on staff," "architectural services" or the substantial equivalent thereof unless the advertiser is a business association authorized to render architectural services pursuant to N.J.S.A. 45:3-17. Specifically, such services shall only be rendered by the following: a sole proprietorship of a licensed architect; a partnership of licensed architects; a partnership of closely allied professionals, including at least one licensed architect; a professional service corporation established pursuant to the "Professional Service Corporation Act" (N.J.S.A. 14A:17-1 et seq.); or a general business corporation holding a Certificate of Authorization from the Board of Architects issued pursuant to the "Building Design Services Act" (N.J.S.A. 45:4B-1 et seq.).

(c) A builder registered pursuant to the "New Home Warranty and Builder's Registration Act" (N.J.S.A. 46B-1 et seq.) or a home improvement contractor may advertise, or offer to perform "design services" either in the construction of one- to two-family homes or in connection with the demolition, enlargement or alteration thereto. A builder or home improvement contractor shall render such services only to the owner-occupant of such dwellings.

(d) An advertisement for design services by a builder or home improvement contractor pursuant to (c) above shall not in any way be limited except as set forth in (e) below, and may contain the following terms or their substantial equivalent:

1. Construction design services;
2. Design;
3. Design services;
4. Design/build;
5. Design/build services; and/or
6. Building design services.

(e) Builders and home improvement contractors shall not advertise, offer or perform design services that involve the preparation of construction documents, which consist of, but are not limited to, those drawings or specifications necessary to support an application for building or other construction permits.

(f) It shall be permissible for a person not authorized to render architectural services to utilize the terms "space planning," "interior design," "interior design services" or the substantial equivalent thereof provided that the design services advertised, offered or performed:

1. Are limited to the function of the interior space within an existing or proposed building;

2. Do not affect the means of egress and life safety of the building, nor involve any alteration or modifications of the building's existing or proposed structure, seismic integrity, or partitions that affect the means of egress and life safety, or its electrical, mechanical, HVAC (heating, ventilation and air conditioning) or plumbing systems;

3. Do not require or involve the skill, training or expertise of a licensed architect; and

4. Do not include the production of construction documents, which consist of, but are not limited to, those drawings or specifications necessary to support an application for a building or other construction permit.

(g) Nothing in this section shall prohibit any person or entity authorized by law to render professional engineering services from utilizing the terms set forth in (d) above in connection with the advertising of professional engineering services.

13:27-3.3 Single family exemption

(a) In accordance with N.J.S.A. 45:3-10, any person in this State may act as a designer of a detached single family dwelling and appurtenances thereto to be constructed by that person solely as a residence for that person or member of that person's immediate family.

(b) A person may design the dwelling and all appurtenances thereto, prepare the construction drawings and file the construction drawings with an affidavit indicating the name of the person who drew the construction drawings.

(c) In lieu of personally preparing the construction drawings, a person may utilize pre-prepared (commercially published, available to the public) construction drawings which bear a certification that they were originally prepared by an architect licensed in any United States' jurisdiction, provided these construction documents are reviewed, signed, sealed and adapted to the specific site by a New Jersey licensed architect. By signing and sealing these construction documents, the New Jersey licensed architect assumes full responsibility for said construction documents, just as if the construction documents were prepared under the direct supervision of the architect.

(d) A person, in lieu of personally constructing the residence, may engage others to perform the work.

13:27-3.4 Impersonal names

(a) Impersonal names shall not be used by individuals, firms, partnerships, associations or any other entities unless they have formed either a professional service corporation established in accordance with N.J.S.A. 14A:17-1, or have formed a general business corporation which qualifies for and holds a Certificate of Authorization as provided for in accordance with N.J.S.A. 45:3-18 and issued by the Board of Architects.

(b) The name of a professional service corporation shall contain the full or last names of one or more of the licensed shareholders, or a name descriptive of the type of professional service which will be provided by the professional service corporation.

(c) The name of a general business corporation which holds a certificate of authorization shall also contain the last names of one or more licensed shareholder(s), or a name descriptive of the professional service which will be provided.

13:27-3.5 Restrictions in titles

(a) A sole proprietorship shall not be conducted under a title which designates or suggests the existence of more than a single principal.

(b) The term "Associates," when used officially in the title of a firm, shall refer only to more than one individual licensed in this State as architects or in a closely allied licensed profession.

(c) When any partner, shareholder, associate or other licensed professional whose name is used in the title ceases to be a member of a firm or partnership for any reason including death or disability, then the title of the firm shall be changed within two years of this disassociation. This requirement does not apply to an organization established as a professional service corporation pursuant to N.J.S.A. 14A-17.1 or a general business corporation established pursuant to N.J.S.A. 45:3-18.

13:27-3.6 Notification of change of address; service of process

(a) A licensed architect shall notify the Board in writing of any change from the address currently registered with the Board and shown on the most recently issued certificate. Such notice shall be sent to the Board by certified mail, return receipt requested, no later than 30 days following the change of address. Failure to notify the Board of any change of address may result in disciplinary action in accordance with N.J.S.A. 45:1-21(h).

(b) Service of an administrative complaint or other Board-initiated action at a licensee's address which is currently on file with the Board shall be deemed adequate notice for the purposes of N.J.A.C. 1:1-7.1 and the commencement of any disciplinary proceedings.

SUBCHAPTER 4. LICENSING PROCEDURES

13:27-4.1 Requirements for admission to examination

(a) No applicant shall be entitled to consideration for admission to the examination for licensure, or shall be permitted to take the examination, while a formal complaint is pending in which the individual is charged with the illegal practice of architecture or while penalties for violations of the Board's statutes and regulations remain unsatisfied.

(b) No later than 60 days prior to the examination, an applicant shall present evidence to the satisfaction of the Board that:

1. The applicant is 18 or more years of age and of good moral character, as established by references from individuals, schools and other records acceptable to the Board;

2. Except as set forth in N.J.A.C. 13:27-4.2, the applicant holds a professional degree in architecture from a college or university whose degree program has been accredited by the National Architectural Accrediting Board (NAAB) not later than two years after graduation; and

3. The applicant has either completed the Intern Development Program (IDP) administered by the National Council of Architect Registration Boards (NCARB) or earned three years of training credits prior to January 1, 1998 pursuant to the provisions of N.J.A.C. 13:27-4.3 through 4.6. At least one of the three years shall consist of diversified training in the office of a registered architect in private practice and shall be under the direct supervision of a registered architect, who need not be the principal in the firm. The Board retains discretion to approve other forms of professional training experience, based on a review of the candidate's work product and areas of architectural work experience.

13:27-4.2 Applicant with a degree from a foreign college or university

(a) An applicant with a degree from a foreign college or university shall obtain, at his or her own expense, and submit to the Board, either:

1. A "Detailed" evaluation by Education Credential Evaluators, Inc., or other evaluation services recognized by the Board certifying that the degree is the equivalent in level, scope and intent of a bachelor or a master degree of architecture that would be accredited in the United States; or

2. If the "Detailed" evaluation does not certify equivalency, a "Comprehensive" evaluation outlining specific academic deficiencies. The application will not be considered until those academic requirements are completed.

13:27-4.3 Training requirements; prerequisites

(a) Training credits shall accrue only after the following educational requirements have been met:

i. After the third full year in an NAAB-approved professional degree program;

ii. After one year in an NAAB-approved professional master's degree program; or

iii. After 96 semester credit hours in an NAAB-approved professional degree program, of which no more than 60 semester credit hours shall be in the general education category.

13:27-4.4 Training requirements prior to January 1, 1998

(a) Prior to January 1, 1998, training credits may be acquired in the following ways:

Item	Description of Training	Percent Credit Allowed	Maximum Credit Allowed
A	Diversified experience in architecture as an employee in the office of a registered architect in private practice under the direct supervision of a registered architect.	100%	No Limit
B	Diversified experience in architecture as an employee of an organization, other than offices of a registered architect in private practice, when the experience is under the direct supervision of a registered architect. Three years of credit will be granted if the Board has pre-approved an organization's intern development program that is comparable to NCARB/IDP.	100%	2 years
C	Experience directly related to architecture, under the direct supervision of a licensed professional engineer (practicing as a structural, civil, mechanical or electrical engineer in the field of building construction); certified landscape architect; or licensed professional planner.	50%	1 year
D	Experience directly related to on-site building construction operations or experience involving physical analyses of existing buildings.	50%	6 mos.
E	A post-professional degree in architecture or teaching or research in a NAAB-accredited architectural program obtained subsequent to a professional degree as defined in N.J.A.C. 13:27-4.1(b)2	100%	1 year

13:27-4.5 Training prior to January 1, 1988; public or private non-profit institutions

Training credits may be earned in a public or private non-profit institution, under the direct supervision of a registered architect, provided that the documentation submitted by that agency or institution demonstrates that it provides diversity of experience comparable in scope to that offered by a private architectural office. In deciding if training represents "diversified experience in architecture," the Board will compare the training provided by the agency or institution with the training requirements mandated by the Board. Such entities shall submit documentation of these training programs to the Board prior to the implementation of the training program.

13:27-4.6 Training prior to January 1, 1998; non traditional settings

(a) A candidate may receive a maximum of two years of IDP training credits while working under the supervision of a registered architect when both the architect and the intern are employees of a firm or corporation that is not an architectural firm in private practice but which meets all of the following criteria:

1. The firm or corporation does not engage in construction other than for its own use and occupancy; and

2. The proposed IDP program of the firm or corporation has been examined and approved by the New Jersey State Board of Architects prior to such time as the IDP training program can commence in that firm or corporation.

13:27-4.7 Training requirements subsequent to January 1, 1998

(a) Effective January 1, 1998, the Intern Development Program (IDP) training criteria and value units as administered by the National Council of Architectural Boards shall be mandatory for all applicants for registration.

(b) Applications for registration submitted after January 1, 1998 shall present evidence of successful completion of the Intern Development Program (IDP) administered by the National Council of Architectural Registration Boards. The IDP training shall be at least three years in duration and shall include at least one year of training in the office of a registered architect in private practice as defined in N.J.A.C. 13:27-3.1.

13:27-4.8 Architect Registration Examination; subjects covered

(a) The subjects covered in the written examination are based on the examinations recommended by the National Council of Architectural Registration Boards and reviewed and approved by the Board as follows:

Division A	Pre-Design
Division B	Site Design
Division C	Building Design
Division D	Structural: General
Division E	Structural: Lateral Forces
Division F	Structural: Long Span
Division G	Mechanical, Plumbing, Electrical and Life Safety Systems
Division H	Materials and Methods
Division I	Construction Documents and Services

(b) Each division successfully passed will be credited to the record of the candidate and may be carried over without limitation.

13:27-4.9 Eligibility of licensed professional engineer for licensure as an architect by limited examination

A professional engineer licensed in the State of New Jersey in good standing, holding an accredited degree in engineering, and without restriction of complaint or charge of illegal practice of architecture shall be eligible for licensure upon successful completion of the following sections of the Architects Registration Examination (ARE): Division A (Pre-Design); Division B (Site Design—Written and Graphic); and Division C (Building Design).

13:27-4.10 Registration by reciprocity

(a) Any person registered or licensed to practice architecture in another jurisdiction of the United States or one of its territories or possessions may be granted registration provided that:

1. The applicant is 18 or more years of age and of good moral character, as established by references from individuals, schools, and other records acceptable to the Board;

2. The applicant is not charged by the New Jersey State Board of Architects or any other jurisdiction with a violation of any law or regulation relating to the practice of architecture or any violation which would indicate a lack of good moral character as required by statute or regulation; or, having been found guilty of a violation, has not satisfied the penalty imposed;

3. The education, training and examination requirements in such other jurisdiction are substantially equal to those required in this State, under current law; and

4. The applicant has provided satisfactory evidence of competency as the Board, in its discretion, may require, including, but not limited to:

i. Exhibits of three architectural projects illustrated in construction documents and photographs;

ii. Oral examination by the Board; and/or

iii. Satisfactory completion of such portion(s) of the Architect Registration Examination (ARE) as the Board may deem necessary.

(b) In cases where the applicant has been granted registration in another United States jurisdiction on the basis of less experience than the three years required for registration in this State, the Board in its discretion may accept, in lieu of the deficiency, periods of experience in the "practice of architecture," as defined in N.J.A.C. 13:27-3.1(e), gained subsequent to registration as an architect in that jurisdiction.

(c) In cases where the applicant has been granted registration in another United States jurisdiction on the basis of education or examination qualifications that are not equal to the requirements of this State, the Board may grant registration upon presentation by the applicant of evidence satisfactory to the Board of at least five years of responsible "practice of architecture," as defined under N.J.A.C. 13:27-3.1(e), while holding a valid license as an architect.

13:27-4.11 Fees

(a) The following fees shall be charged by the Board:

1. Application Fee	$ 50.00
2. Initial License Fee	
i. If paid during the first year of a biennial renewal period	160.00
ii. If paid during the second year of a biennial renewal period	80.00
3. Biennial Renewal Fee	160.00
4. Reciprocity Application Fee (plus initial license fee)	75.00
5. Replacement or Duplicate Seal Press	40.00
6. Duplicate wall certificate	25.00
7. Late Fee	50.00
8. Verification of Licensure	30.00
9. Reinstatement Fee	100.00
10. Roster	15.00

(b) The "Roster of Architects" shall be issued without charge to State, county and municipal government agencies and to all architects and landscape architects listed therein.

(c) Certificate of Authorization fees shall be as follows:

1. Application fee	$100.00
2. Initial registration	
i. If paid in the first year of a biennial renewal period	50.00
ii. If paid in the second year of a biennial renewal period	250.00
3. Biennial Renewal	500.00

SUBCHAPTER 5. RULES OF PROFESSIONAL CONDUCT

13:27-5.1 Competence

(a) An architect shall at all times recognize the primary obligation to protect the health, safety and welfare of the public in the performance of professional duties, shall act with reasonable care and competence, and shall apply the technical knowledge and skill which are ordinarily applied by architects of good standing, practicing in the same locality.

(b) An architect shall take into account all of the applicable Federal, state, county and municipal laws, regulations and ordinances including, but not limited to, New Jersey Uniform Construction Code Regulations (N.J.A.C. 5:23); zoning ordinances; master plans; site plan regulations. While an architect may rely on the advice of other professionals (for example: attorneys, other architects, engineers, landscape architects and other qualified persons) as to the intent and meaning of such statutes and regulations, once having obtained such advice, an architect shall not knowingly proceed in violation of such statutes and regulations.

(c) An architect shall undertake to perform professional services only when he or she, together with those whom the architect may engage as consultants, are qualified by education, training, and experience in the specific scope of contractual obligation and technical areas involved.

(d) No person shall practice architecture if such person is incapable, for medical or any other good cause, of discharging the functions of a licensee in a manner consistent with the public health, safety and welfare.

13:27-5.2 Duty to report and cooperate

(a) If, in the course of his or her work on a project, an architect becomes aware of a decision taken by his or her employer or client, against the architect's advice, which violates applicable Federal, state, county or municipal building laws and regulations and which would, in the architect's exercise of reasonable judgment, materially and adversely affect the health, safety and welfare of the public, the architect shall:

1. Report the decision to the local municipal construction official or other public official charged with the enforcement of the applicable state or municipal building laws and regulations;

2. Refuse to consent to the decision; and

3. In circumstances where the architect reasonably believes that other such decisions will be taken notwithstanding his or her objection, terminate his or her services with reference to the project.

(b) An architect possessing knowledge of an alleged violation by another architect of these rules or any act administered by the Board shall report such alleged violation to the Board when it appears to constitute a threat of harm to the public health, safety and welfare.

(c) An architect shall not deliberately make a false statement or fail deliberately to disclose a material fact requested in connection with his or her application for registration or renewal, or any other official request for information made by the Board.

(d) An architect shall not assist the application for registration of a person known by the architect to be unqualified in respect to education, training, experience, or character.

(e) An architect shall not impede the application of a registrant for licensure by failure to cooperate with the Board in its request for information.

13:27-5.3 Conflict of interest

(a) An architect shall provide professional services to the client competently and independently through contractual arrangements with the client which safeguard the exercise of unprejudiced judgment of the architect.

(b) An architect shall not accept compensation for his or her services from more than one party on a project unless the circumstances are fully disclosed and agreed to in writing by all interested parties.

(c) An architect shall not solicit or accept compensation, goods or services from material or equipment manufacturers or suppliers in return for specifying or endorsing their products.

(d) When acting as the interpreter of construction contract documents and the judge of construction contract performance, an architect shall render decisions impartially, favoring neither party to the contract.

13:27-5.4 Full disclosure

(a) An architect making public statements on architectural questions shall disclose when he or she is being compensated for making such statements.

(b) An architect shall accurately disclose to a prospective or existing client or employer his or her qualifications and the scope of his or her responsibility in connection with work for which he or she is claiming credit.

13:27-5.5 Professional practice and procedures

(a) Each office maintained for the purpose of providing architectural services or other professional work shall have an architect in responsible charge, as defined in N.J.S.A. 45:3-1.1(l).

1. A licensee engaged in any of the following acts or practices shall be deemed not to be in responsible charge:

i. The regular and continuous absence from principal office premises from which professional services are rendered, except for performance of field work or presence in a field office maintained exclusively for a specific project;

ii. The failure to personally inspect or review the work of subordinates where necessary and appropriate;

iii. The rendering of a limited, cursory or perfunctory review of plans for a building or structure in lieu of an appropriate detailed review; and/or

iv. The failure to be personally available on a reasonable basis or with adequate advance notice for consultation and inspection where circumstances require personal availability.

(b) Except as set forth in N.J.A.C. 13:27-3.3(c), an architect shall not sign or seal drawings, construction documents, reports or other professional work for which he or she does not have direct professional knowledge and direct supervisory control; provided, however, that in the case of the portions of such professional work prepared by the architect's consultants, registered under this or another professional registration law of this jurisdiction, the architect may sign or seal that portion of the professional work if the architect has reviewed such portion, has coordinated its preparation, and intends to be responsible for its adequacy.

(c) An architect shall not aid nor abet an unlicensed individual or entity in the practice of architecture by permitting his or her name, seal, and/or signature to be used in connection with an individual, firm or corporation not authorized by law to practice architecture.

(d) An architect shall neither offer nor make any gifts with the intent of influencing the judgment of an existing or prospective client in connection with a project in which the architect is interested.

SUBCHAPTER 6. CERTIFICATES; SEALS; TITLE BLOCKS

13:27-6.1 Issuance of Certificates

Upon approval by the Board and payment of all fees, an architect shall be issued a certificate and seal press as proof of licensure and authorization to practice.

13:27-6.2 Renewals of license and Certificate of Authorization

(a) A licensee shall renew his or her license and/or a Certificate of Authorization on or prior to its expiration date as indicated on the biennial renewal notice.

(b) If the renewal application is submitted within 30 days after the expiration date, the licensee shall pay, in addition to the biennial renewal fee, the late fee set forth in N.J.A.C. 13:27-4.13.

(c) Failure to renew a license or Certificate of Authorization within 30 days of the expiration date of a biennial period will require payment of reinstatement fees and biennial renewal fees as set forth in N.J.A.C. 13:27-4.13.

13:27-6.3 Reinstatement of Certificates

(a) An architect whose license has expired and who seeks reinstatement shall provide the following to the Board prior to being considered for reinstatement of licensure:

1. Payment of the renewal fee for the current biennial period and the appropriate renewal fees for all biennial periods since the date the license expired;

2. Payment of the reinstatement fee set forth in N.J.A.C. 13:27-4.13; and

3. A notarized affidavit delineating the professional activities in which he or she has engaged since his or her license expired including a listing of all projects for which architectural services were performed.

(b) An applicant for reinstatement found to have practiced architecture in the State of New Jersey since the date the license expired shall be required to pay, in addition to the fees set forth above, a penalty for unlicensed practice as determined by the Board.

(c) A licensee may be denied reinstatement in the event that charges relating to the unlawful or improper practice of architecture are pending against the architect in any state or jurisdiction.

(d) The applicant for reinstatement shall be required to produce satisfactory evidence of competency such as the Board, in its discretion, may require.

1. Such evidence may consist of, but not be limited to, exhibits of three architectural projects illustrated by construction documents and photographs and may include oral examination.

2. The Board may require the applicant to demonstrate evidence of efforts to maintain and advance his or her knowledge of the art and science of architecture during the period of non-licensure.

13:27-6.4 Seals

(a) A registrant shall seal architectural documents only with seal presses purchased or exchanged through the Board.

(b) Rubber stamps shall not be used for the purpose of sealing documents.

(c) Upon the death of a registrant or upon forfeiture of a certificate, the seal shall be returned to the Board.

(d) The family of a deceased architect may petition the Board to retain an architect's seal press as a memento. The family shall be responsible for the safekeeping of the seal to prevent its use in the illegal practice of architecture.

(e) Failure to return a seal rendered invalid by non-payment of renewal fees shall subject the individual to such penalties as provided by law and may be grounds for refusal of the Board to reinstate a license.

13:27-6.5 Signing and sealing documents

(a) The architect in responsible charge shall sign, date and seal all original tracings of construction drawings and the title page of the specifications prepared by the architect or under his or her supervision on the original tracing. In lieu of affixing the personal signature only to the original tracing, the architect may sign, date and seal each copy of each drawing prior to submission to the client or filing with a public agency.

(b) All certifications that amend, clarify, or modify construction documents prepared by the architect in responsible charge shall be signed and sealed prior to forwarding to a public agency.

13:27-6.6 Title block on drawings; general requirements; form; removal

(a) A title block shall appear on all drawings and site plans. Title block information is not required on renderings. Similar information shall appear on the title page of all specifications which are prepared, signed and sealed by the architect in responsible charge.

(b) The title block shall be in such form as set forth in N.J.A.C. 13:27-6.7.

(c) The title block shall be distinct and separate from any other title block, box, plaque or any similar device of illustration or lettering included on the drawings or on the title page of the specifications.

(d) The title block shall be affixed on each drawing in such a manner as to reproduce clearly on all prints and reproductions thereof.

(e) No person shall remove a title block from any print, reproduction, or electronic media.

(f) A non-licensed person's name, other than the name of the owner or lessee of the building, shall not appear within the title block.

13:27-6.7 Title block contents; requirements by form of architectural practice

(a) When the architect practices as an individual or sole proprietor the title block shall contain:

1. The full name of the architect;
2. The title "architect";
3. The address of the architect;
4. A space for the name of the client and the location of the project; and
5. The name, license number, and space for the handwritten signature of the architect in responsible charge, and the date when signed.

(b) When two or more licensed architects practice architecture as a firm or partnership, the title block shall contain:

1. The firm name;
2. The title "architects";
3. The address of the firm or partnership;
4. A space for the name of the client and the location of the project; and
5. The name, license number, and space for the handwritten signature of the architect in responsible charge, and the date when signed.

(c) When professionals practice architecture as a professional service corporation organized under N.J.S.A. 14A:17-1 et seq., the title block shall contain:

1. The professional service corporation name;
2. The title "architects," and titles of any other closely allied professionals;
3. The address of the professional service corporation;
4. A space for the name of the client and the location of the project; and
5. The name, license number, and space for the handwritten signature of the architect in responsible charge, and the date when signed.

(d) Title block contents for a general business corporation organized under N.J.S.A. 45:3-18 and holding a Certificate of Authorization shall contain:

1. The general business corporation name, Certificate of Authorization number and expiration date;
2. The title "architects" or titles of any other "closely allied professionals";
3. The address of the general business corporation;
4. The name and location of the project; and
5. The full name, license number, and space for the handwritten signature of the architect in responsible charge, and the date when signed.

(e) When an architect is a subcontractor on an engineering project pursuant to the Building Design Services Act (N.J.S.A. 45:4B-8), the architect shall include a secondary title block with all the information required in (a), (b), (c) or (d) above. Reference to the name and location of the project need not be repeated in the secondary title block.

(f) An architect practicing as an employee of a business entity which does not offer architectural services to the public shall use a title block which contains the name of the entity as the "owner" and all other elements required by this section.

(g) The title block may contain the initials of the draftsperson or checker, and dates, drawing numbers, revision numbers and such similar incidental items as are customarily used in the architects' offices.

13:27-6.8 Submission of title block form for approval

Any architect may submit a proposed form of title block to the State Board of Architects for approval.

SUBCHAPTER 7. PERMISSIBLE DIVISION OF RESPONSIBILITY IN SUBMISSION OF SITE PLANS AND MAJOR SUBDIVISION PLATS

13:27-7.1 General provisions

(a) All words, terms, and phrases used in this subchapter shall be as defined in the Municipal Land Use Act, N.J.S.A. 40:55D-1 et seq.

(b) Preparation and submission of the various elements of a preliminary or final site plan or major subdivision plat shall be within the professional scope of the various professions as listed in this subchapter.

13:27-7.2 Depiction of existing conditions on a site plan

(a) Showing existing conditions and exact location of physical features including metes and bounds, drainage, waterways, specific utility locations, and easements: By a land surveyor.

1. Survey information may be transferred to the site plan if duly noted as to the date of the survey, by whom, and for whom.

(b) Vegetation, general flood plain determination, or general location of utilities, buildings, or structures: By an architect, planner, engineer, land surveyor, certified landscape architect, or other person acceptable to the reviewing governmental body.

13:27-7.3 Preparation of site plan

(a) The location of proposed buildings and their relationship to the site and the immediate environs: By an architect or engineer.

(b) The locations of drives; parking layout; pedestrian circulation; and means of ingress and egress: By an architect, planner, engineer, or certified landscape architect.

(c) Drainage facilities for site plans of ten acres or more; or involving stormwater detection facilities; or traversed by a water course: By an engineer only.

(d) Other drainage facilities: By an architect or engineer.

(e) Utility connections and on tract extensions: By an engineer or architect.

(f) Off tract utility extensions: By an engineer only.

(g) On site sanitary sewage disposal or flow equalization facilities: By an engineer only.

(h) Preliminary floor plans and elevation views of buildings illustrating the architectural design of a project: By an architect, except when the building is part of an engineering or industrial project, floor plans and elevation views may be by an engineer.

(i) Landscaping, signs, lighting, screening or other information not specified above: By an architect, planner, engineer, certified landscape architect, or other person acceptable to the reviewing governmental body.

(j) The general layout of a conceptual site plan for a multiple building project, showing the development elements including their relationship to the site and immediate environs: By an architect, planner, engineer, or certified landscape architect.

13:27-7.4 Preparation of a major subdivision plan

(a) The general location of facilities, site improvements, and lot layouts: By an architect, engineer, land surveyor, planner, or certified landscape architect.

(b) The design and construction details of all public improvements including street pavements, curbs, sidewalks, sanitary sewage, storm drainage facilities: By an engineer only.

(c) Final subdivision map with metes and bounds: By a land surveyor only.

13:27-7.5 Effect of local ordinances

(a) Informal site plans not required by local ordinances are excluded from this rule.

(b) No municipal or county ordinance, policy or action purporting to define the scope of professional activity of architects, engineers, land surveyors, planners, or certified landscape architects in the preparation of site plans or major subdivision shall reduce or expand the scope of professional practice recognized by the Boards.

SUBCHAPTER 8. CERTIFIED LANDSCAPE ARCHITECTS

13:27-8.1 Definitions

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

"Board" means the New Jersey State Board of Architects.

"Certified landscape architect" means an individual who, by reason of his or her knowledge of natural, physical, and mathematical sciences, and the principles and methodology of landscape architecture and landscape architecture design acquired by professional education, practical experience, or both, is qualified to engage in the practice of landscape architecture and is certified by the board as a landscape architect.

"Committee" means the Landscape Architect Examination and Evaluation Committee of the New Jersey State Board of Architects.

"Practice of landscape architecture" means any service in which the principles and methodology of landscape architecture are applied in consultation, evaluation and planning, including the preparation and filing of sketches, drawings, plans and specifications, and responsible administration of contracts relative to projects principally directed at the functional and aesthetic use of land. Nothing contained in this section shall be construed to restrict or otherwise affect the right of any person or corporation to engage in the practice of landscape architecture, but no person shall hold himself or herself out as, or use the title "landscape architect," unless he or she has been certified by the Board as a landscape architect.

13:27-8.2 Office of the committee

The office of the Committee shall be that which is maintained by the Board pursuant to N.J.A.C. 13:27-2.2, Administration, under the supervision of the person selected to serve as executive director.

13:27-8.3 Committee organization

(a) The committee shall, at an annual meeting to be held in July of each year, elect from its membership a chairperson and vice-chairperson.

(b) The committee shall adopt annually a schedule of regular meetings. Special meetings may be held at the call of the chair or at the action of a quorum of the membership.

(c) A quorum of the committee shall consist of three members. No affirmative action at a meeting shall be taken without at least three affirmative votes.

(d) The committee shall keep a record of its proceedings and a record of all applicants for certification, showing for each the date of application, name, age, education, and other qualifications, place of practice and place of residence, whether or not an examination was required, and whether the applicant was rejected or a certificate granted, and the date of that action.

13:27-8.4 Approval of landscape architecture curricula and credentials

(a) For purposes of this section, any educational program accredited by the Landscape Architectural Accreditation Board of the American Society of Landscape Architects shall be deemed an approved program.

(b) An applicant for certification as a landscape architect who is a graduate of a school or program not accredited by the Landscape Architectural Board shall provide to the Committee, in addition to a certified transcript of his or her courses, a true and accurate course description for each of the landscape architecture courses for which the candidate is seeking credit toward certification. The committee shall, in its consideration of the academic program, compare the degree to the standards promulgated by the Landscape Architecture Accreditation Board. Thereafter, the Committee may, in its discretion, require the candidate to appear before the Committee for a personal interview and to present representative samples of his or her landscape architecture work.

13:27-8.5 Application for certification; general requirements

(a) Each candidate for certification as a landscape architect shall apply to the Board on the form and in the manner prescribed by the Committee. The board shall immediately refer each completed application to the Committee for appropriate action. Each applicant shall furnish evidence satisfactory to the Committee that he or she:

1. Is of good moral character;

2. Is the holder of a bachelor's or higher degree in landscape architecture from a college or university having a landscape architecture curriculum approved by the Committee;

3. Has engaged in landscape architectural work satisfactory to the Committee to an extent that his or her combined college study and practical experience total at least six years, four years of which must be college study with three years in a landscape architecture curriculum and two years of which must be practical landscape architecture experience approved by the Committee. The practical landscape architecture experience shall be obtained after the completion of the educational requirements; and

4. Has successfully completed the Landscape Architect Registration Examination (LARE) and an examination on New Jersey plant materials, soil types, geology and laws and regulations governing land use and planning, including the Municipal Land Use Law, N.J.S.A. 40:55D-1 et seq.

13:27-8.6 Certification of persons holding certificate from another state or authority

(a) All reciprocal applicants for certification as landscape architects in New Jersey shall take and pass an examination on New Jersey plant materials, soil types and geology, as well as laws and regulations governing land use and planning including the Municipal Land Use Law, N.J.S.A. 40:55D-1 et seq.

(b) The Committee shall issue a certificate to any applicant who holds a license or certificate in good standing as a landscape architect from a legally constituted agency in any other state, district or territory of the United States, provided that the requirements for licensure or certification of the issuing agency are substantially equal to those of the Committee and board, and provided further that the applicant meets all applicable requirements of N.J.S.A. 45:3-1 et seq.

(c) Except as set forth in (d) below, the Committee shall exempt from examination an applicant who holds a current Council of

Landscape Architectural Registration Board (CLARB) certification and who meets all other applicable requirements of N.J.S.A. 45:3-1 et seq. The applicant shall submit current CLARB certification records to the Committee for review.

(d) When the applicant has obtained CLARB certification based upon qualifications not substantially equal to those required by the State of New Jersey, the Committee shall require the applicant to:

1. Take the pertinent portion or portions of the LARE that test(s) the areas of landscape architecture education or experience in which the applicant is deficient; or

2. Demonstrate five years of experience in the practice of landscape architecture subsequent to licensure or certification in the base jurisdiction.

13:27-8.7 Initial certification and renewals

(a) A Certificate holder shall renew his or her certificate on or prior to its expiration date as indicated on the biennial renewal notice.

(b) If the renewal application is submitted within 30 days after the expiration date, the licensee shall pay, in addition to the biennial renewal fee, the late fee set forth in N.J.A.C. 13:27-8.23.

(c) Failure to renew a certificate within 30 days of the expiration date of a biennial period will require payment of reinstatement fees and biennial renewal fees as set forth in N.J.A.C. 13:27-8.23.

13:27-8.8 Duplicate certificates

A duplicate certificate may be issued upon the presentation to the board of the fee as provided in N.J.A.C. 13:27-8.23 with an affidavit or certified statement attesting that the original was either lost, destroyed, mutilated or is otherwise no longer in the custody of and cannot be recovered by the certified landscape architect; or attesting to the fact that the certified landscape architect is employed in more than one location.

13:27-8.9 Seal and signature

(a) Every certified landscape architect shall have a seal of a type recommended by the committee and approved and issued by the Board, which shall contain the name of the landscape architect, his or her certificate number, the legend "Certified Landscape Architect" and such other words or figures as the committee may deem necessary.

(b) All working drawings and specifications prepared by the landscape architect or under his or her supervision shall be signed on the original with the personal signature of the landscape architect. Thereafter, all copies of such drawings and specifications shall be sealed prior to submission to the client or filing with a public agency.

(c) A certified landscape architect shall provide the following information in a title block which shall be placed on all contract drawings prepared under his or her direction. The information shall appear legibly on the drawing and shall be clearly reproducible.

1. The full name of the certified landscape architect as it appears on the certificate issued by the Board;

2. The signature of the certified landscape architect;

3. The license number and title: New Jersey Certified Landscape Architect; and

4. The date when signed.

(d) Other information may appear with or within the title block provided that the required information is distinct and the name of the certified landscape architect is readily discernible from the other information on the document.

13:27-8.10 Registration renewal; continuing education requirements

The Committee shall not issue a registration renewal application for any biennial period unless the applicant submits proof that he or she has completed courses of continuing professional education of the types and number of hours specified in this subchapter. Proof of completion of the required number of continuing education hours shall be in the form outlined in N.J.A.C. 13:27-8.14. In the event a registrant fails to meet the continuing education requirements, the landscape architect certificate will not be renewed until all delinquent credit shall have been remediated to the satisfaction of the Committee and Board and reinstatement and registration fees for each two years or portion thereof in which the holder is in arrears have been paid pursuant to N.J.S.A. 45:3A-12.

13:27-8.11 Credit hour requirements

(a) After the initial biennial registration period, each applicant for a renewal shall be required to complete, for each succeeding biennial period, a minimum of 30 credit hours of continuing education.

(b) A maximum of 15 credit hours in excess of the required 30 credit hours may be carried over into a succeeding biennial period.

(c) A registrant on inactive status who seeks to reactivate his or her registration shall submit satisfactory proof to the Committee of successful completion of continuing education credit hours in an amount at least equal to the amount required for an active registration renewal.

13:27-8.12 Continuing education programs and other sources of continuing education

(a) The registrant may obtain continuing education credit units from the following:

1. Programs approved by the Committee, including, but not limited to, university-sponsored or university-level seminars, conferences and other programs offered for the purpose of keeping the registrant apprised of advancements and new developments in the profession. Suitable programs include, for example, any of the subjects tested in the Landscape Architect Registration Examination (LARE), such as professional practice, design (conceptual site design, planting design, comprehensive site design), or design implementation (grading construction details, layout);

2. Graduate course work beyond that required for professional licensure, at university-sponsored programs or at university-level, subject to Committee approval; and/or

3. Participation, other than as a student, in university-level education processes and programs, subject to Committee approval. Examples of activities for which credit may be granted are teaching, program development, authorship of textbooks or articles, or similar activities which are determined to be equivalent to obtaining continuing education.

(b) An individual, group or association seeking course or program approval may impose a reasonable differential in course or program fees based upon membership within a group or association. However, in no event shall a sponsoring individual, group or association completely exclude from the course or program any licensee who is not a member of the group or association.

(c) The Committee shall maintain a list of all approved programs, courses and lectures at the Committee offices and shall furnish this information to registrants upon request.

13:27-8.13 Continuing education credit unit calculations

(a) Credit for continuing education shall be granted as follows for each two-year period:

1. For attendance at programs approved by the Committee, one credit for each hour of attendance at an approved course. Credit will not be granted for courses which are less than three instructional hours long. Completion of an entire course or segment of course instruction is required in order to receive any continuing education credit.

2. For successful completion of graduate course work taken beyond that required for professional licensure, a maximum of nine hours of credit for each course.

3. For publication in a refereed professional journal of a copyrighted article related to the profession, nine credit hours per article to a maximum of 18 per biennial cycle.

4. For teaching and research appointments at a university level, nine hours for each new course, to a maximum of 18 hours per biennial cycle. "New" means new to the person teaching it, that is, a course which the registrant has never taught before in any educational setting.

13:27-8.14 Reporting of continuing education units

(a) Prior to the expiration of a biennial registration, the Committee shall request each registrant to complete a renewal form listing

the continuing education programs and credit hours completed during the previous registration cycle.

(b) Documentation of completed continuing education programs shall be maintained by each registrant for a period of no less than five years.

(c) All registrants shall be subject to audit by the Committee and shall submit documentation of completed continuing education programs upon request. Failure to provide requested documentation or falsification of any information submitted to the Committee may result in an appearance before the Committee, or penalties and/or suspension of registration after a hearing.

(d) Documentation of continuing education requirements shall consist of the following:

1. For advance approval of attendance at seminars, conferences and other programs, a descriptive outline of the program or a description as prepared by the sponsor, including dates and hours;

2. For subsequent approval of the events in (d)1 above, written verification by the sponsor of attendance;

3. For publication in a national professional journal, submission of the published article; and

4. For teaching or research appointments, a statement from the appropriate school authority verifying the appointment.

(e) Registrants may submit each documentation in (d) above to the Committee 60 days prior to enrollment or participation in any of the activities in (d) above, to confirm acceptability by the Committee of the anticipated credit hours.

13:27-8.15 Waiver of continuing education requirements

(a) The Committee may, at its discretion, waive or modify continuing education requirements on an individual basis for reasons of hardship, such as illness or disability which prevents attendance at or completion of continuing education, or other good cause as demonstrated by a licensee.

(b) Any registrant seeking a waiver of the continuing education requirements must apply to the Committee in writing and set forth with specificity the reasons for requesting the waiver. The registrant shall also provide the Committee with such additional information as it may reasonably request in support of the application.

13:27-8.16 Responsibilities of continuing education sponsors

(a) Prior to representing that a course or seminar has been approved, a sponsor of continuing education for landscape architects shall submit the following, for each course offered, for evaluation by the Committee:

1. A detailed description of course content and estimated hours of instruction which shall be consistent with the requirements of N.J.A.C. 13:27-8.12; and

2. A summary of qualifications of the lecturer.

(b) The sponsor shall monitor the attendance at each approved course and furnish to each enrollee a verification of attendance, which shall include at least the following information:

1. The title, date and location of course offering;

2. The name and registration number of the attendee;

3. The number of hours awarded by the sponsor and, if known, the number of continuing education hours approved by the Committee, and

4. The name and signature of the officer or responsible party and seal of the organization.

(c) The sponsor shall solicit evaluations from both the participants and the instructors.

13:27-8.17 Continuing education credit by endorsement

(a) A New Jersey registrant who is authorized by licensure/certification/registration to practice landscape architecture in another state shall satisfy the credit hour requirements of N.J.A.C. 13:27-8.11 by submitting the following:

1. Certification from the appropriate governmental authority in that other state confirming that the person has satisfactorily completed all continuing education credits required for renewal of licensure/certification/registration in that state;

2. Proof that that state is the primary practice location of the New Jersey registrant; and

3. Proof that that state requires review and approval of continuing education of rigor and extent which are substantially equal to the requirements imposed by New Jersey.

13:27-8.18 Committee certificate for endorsement of continuing education credit hours

A registrant of this State who is in good standing may request of the Executive Director of the Board of Architects a document attesting that the official record confirms satisfactory completion of all New Jersey continuing education requirements. Good standing for this purpose means the registrant is currently registered, has paid all required fees, and is not the subject of any disciplinary complaint or under current disciplinary sanction.

13:27-8.19 Rules of professional conduct

(a) A landscape architect shall at all times recognize the primary obligation to protect the safety, health and welfare of the public in the performance of professional duties. If the landscape architect's judgment is disregarded by the employer or client under circumstances where the safety, health and welfare of the public are endangered, the employer or client shall be informed of the possible consequences and the landscape architect shall notify such other proper public authority as may be appropriate, of the situation.

(b) A landscape architect may accept an assignment or employment requiring education or experience outside of his or her field of competence, but only to the extent that the services are restricted to those phases of the project in which he or she may, without undue cost or hardship to the client, reasonably become qualified. All other phases of such project shall be performed by qualified associates, consultants, or employees in conformance with the statutes and rules governing their respective professions.

(c) A landscape architect shall not affix a personal signature and/or seal to any plan or document dealing with subject matter in which there is a lack of competence by virtue of education or experience, nor to any such plan or document not prepared under his or her direct supervision and control.

(d) A landscape architect shall be completely objective and truthful in all professional reports, statements or testimony and shall include all relevant and pertinent information.

(e) When issuing any statements, criticisms or arguments on matters connected with public policy which are inspired or paid for by an interested party, or parties, a landscape architect shall preface such comments by explicit personal identification, by disclosing the identity of the party or parties on whose behalf he or she is speaking, and by revealing the existence of any pecuniary interest he or she may have in the instant matters.

(f) A landscape architect shall not accept compensation, financial or otherwise, from more than one party for services on the same project, or for services pertaining to the same project, unless the circumstances are fully disclosed to, and agreed to by, all interested parties.

(g) A landscape architect shall not solicit or accept financial or other valuable considerations from material or equipment suppliers for specifying their products unless such consideration is disclosed to the client.

(h) A landscape architect shall not solicit or accept gratuities or anything of value not related to work performed, directly or indirectly, from contractors, their agents, or other parties dealing with his or her client or employer in connection with work for which he or she is responsible.

(i) When in public service as a member, advisor or employee of a governmental body or department, a landscape architect shall not participate in considerations or actions with respect to services provided by the individual or the individual's professional organization in private practice.

(j) A landscape architect shall not solicit or accept a contract from a government body on which a principal or officer of his or her organization serves as a member.

(k) A landscape architect shall not offer to pay, either directly or indirectly, any commission, political contribution, gift or other consideration in order to secure or retain work, exclusive of securing positions through employment agencies.

(l) A landscape architect shall not falsify or permit misrepresentation of academic or professional qualifications. He or she shall not misrepresent or exaggerate degrees of responsibility in or for the subject matter of prior assignments. Brochures or other presentations incident to the solicitation of employment shall not misrepresent pertinent facts concerning employers, employees, associates, joint ventures, or past accomplishments with the intent and purpose of enhancing his or her qualifications and work.

(m) A landscape architect shall not knowingly associate with or permit the use of a personal name or firm name in a business venture by any person or firm which he or she knows, or has reason to believe, is engaging in business or professional practices of a fraudulent or dishonest nature or is otherwise engaging in unlawful activities.

(n) All advertisements and public representations of certificate holders which make specific reference to service as a "landscape architect" shall list the name and certificate number of the landscape architect. If the certificate holder conducts the practice under a corporation or trade name, the advertisement/public representation may list the business name under which the practice is conducted but shall also conspicuously disclose the name and certificate number of at least one of the principal practitioners. This requirement applies to all advertising locations, including, but not limited to, listings in a telephone or other consumer information directory, the public media, commercial property, and motor vehicles.

1. Landscape architects, whose advertisements/listings in a telephone or other consumer information directory do not comply with this requirement, shall immediately notify the directory publisher of the additional data which shall be published in the next available directory in which the landscape architect intends to continue such advertisement/listing. The certificate holder, personally or through the business entity, shall retain a copy of the notification which shall be made available for inspection at Board request.

(o) If a landscape architect has knowledge or reason to believe that another person or firm may be in violation of any of these provisions, he or she shall present such information to the board in writing and shall cooperate with the board in furnishing such further information or assistance as may be required by the Board.

13:27-8.20 Nomenclature for non-certified persons

(a) Any individual who is not a certified landscape architect as defined by N.J.S.A. 45:3A-2 may advertise and offer services to the public provided that the description of the advertiser's title and services conforms to the requirements of (b) below.

(b) An individual who is not a certified landscape architect as defined in N.J.S.A. 45:3A-2 shall not, for example, use the following titles or description of services:

TITLES

Landscape Architect
Certified Landscape Architect
Licensed Landscape Architect
Registered Landscape Architect
Professional Landscape Architect

DESCRIPTIONS OF SERVICES

Landscape Architecture
Landscape Architectural Design
Landscape Architectural Construction
Landscape Architectural Planting Design
Landscape Architectural Service

(c) The titles and descriptions listed in (b) above are not meant to be all-inclusive.

13:27-8.21 Fees

(a) The following fees shall be charged by the Board of Architects for Landscape Architect Certification matters. Unless otherwise provided herein, all fees are nonrefundable.

1. Application Fee	$125.00
2. Examination fee for the New Jersey portion of the Landscape Architect Registration Examination (LARE) when Board administered:	$ 35.00
3. Initial Certification Fee (including seal press)	
i. If paid during the first year of a biennial renewal period	$160.00
ii. If paid during the second year of a biennial renewal period	$ 80.00
4. Biennial Renewal Fee	$160.00
5. Late Fee	$ 50.00
6. Reinstatement Fee	$100.00
7. Reciprocity Fee plus initial certification fee and application fee	$75.00
8. Duplicate certificate fee	$ 25.00
9. Replacement seal press	$ 40.00
10. Verification of Certification	$ 25.00
11. Roster of certified landscape architects (provided free to all registrants and public agencies)	$ 15.00

13:27-8.22 Notification of change of address; service of process

(a) Landscape architects shall notify the Board in writing of any change from the address currently registered with the Board and shown on the most recently issued certificate. Such notice shall be sent to the Board by certified mail, return receipt requested, no later than 30 days following the change of address. Failure to notify the Board of any change of address may result in disciplinary action in accordance with N.J.S.A. 45:1-21(h).

(b) Service of an administrative complaint or other Board-initiated action at a licensee's address currently on file with the Board shall be deemed adequate notice for the purposes of N.J.A.C. 1:1-7.1 and the commencement of any disciplinary proceedings.

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF CHIROPRACTIC EXAMINERS
Practice Identification
Reproposed New Rule: N.J.A.C. 13:44E-2.6

Authorized By: Board of Chiropractic Examiners,
Robert Tarantino, D.C., President.
Authority: N.J.S.A. 45:9-41.23(h).
Proposal Number: PRN 1994-636.

Submit written comments by January 18, 1995 to:
Kay McCormack, Executive Director
State Board of Chiropractic Examiners
Post Office Box 45004
Newark, New Jersey 07101

The agency proposal follows:

Summary

The State Board of Chiropractic Examiners is reproposing a new rule, N.J.A.C. 13:44E-2.6, Practice identification, which also addresses the topic of licensees advertising areas of the profession in which they developed an emphasis. The rule was originally proposed on September 7, 1993 as PRN 1993-497 at 25 N.J.R. 3934(a).

Subsection (a) defines the academic guidelines by which a licensee shall be deemed to have earned either a chiropractic certificate or diplomate. The educational requirements adhere to commonly acknowledged national standards that serve as the basis for assuring the public that when chiropractors identify themselves and their acquired degrees for professional purposes, they will do so only after having fulfilled programs of study that meet with the Board's approval.

Based upon public comment and renewed Board discussion, the definitions of "certified" and "diplomate" have been expanded in this reproposed new rule to include (i) a program offered at a Board-approved institution of chiropractic and (ii) a Board-approved interdisciplinary program. The original definitions included certifications earned only at programs approved by one of three chiropractic professional entities.

Subsection (b) requires licensees to identify themselves for professional purposes in a manner clearly indicating the chiropractic profession and advises licensees of the terms which may be used to do so. The identifying term must appear immediately adjacent to the full name of the licensee in all forms of advertising and public announcement.

Similarly, subsection (g) requires the term "chiropractic" to be used in conjunction with advertised claims of having developed an emphasis in a particular area of the profession in order to assure that the consumer will not be misled and believe that the advertiser is a medical doctor rather than a chiropractor.

Subsection (c) prohibits licensees from advertising nonacademic degrees or professional society memberships so as to ensure that the public is provided only with information that will materially aid it in selecting an appropriately qualified chiropractor.

Subsection (d) requires that any licensee who advertises certification or diplomate status shall have met all requirements of subsection (a). All advertisements must include the full name of the agency that provided the degree and, upon Board request, the licensee must validate the achievement of certification or diplomate status.

Subsection (e) honors the National Board of Chiropractic Examiners' request to prohibit licensees from creating advertisements that use the term "Diplomate of National Board of Chiropractic Examiners." The prohibition protects against a deceptive practice; namely, a claim of diplomate status which suggests and implies specialized, advanced training when, in fact, a diplomate from the National Board merely reflects passage of the National Board's exam.

In keeping with the Board's policy concerns regarding the notion of specialties within the chiropractic profession, subsection (f) provides that only licensees who have achieved certification or diplomate status as defined in subsection (a) will be permitted, when advertising, to use any word or phrase connoting advanced training and education, such as the word "specialist."

The reproposed new rule deletes the previously proposed requirement that licensees qualified to advertise as specialists limit or restrict their practice to the specialty area.

The reproposed new rule also clarifies that licensees without certification or diplomate status shall not represent themselves to the public as "specialists" but may draw attention to their voluntarily having adopted a restricted scope of practice by the use of the words "limited to."

Subsection (h) provides that a licensee who violates any of the provisions of this rule will be deemed to have engaged in professional misconduct and will thus be subject to the imposition of penalties and costs and other appropriate disciplinary sanctions.

Social Impact

The reproposed new rule protects consumers in a number of positive ways. The Board's decision to clarify the educational requirements that licensees who advertise certification and diplomate status must meet seeks to guarantee the consumer relying upon such information of being served by chiropractors whose educational backgrounds comply with national academic standards. Moreover, requiring use of standardized identifying terms immediately adjacent to a licensee's name and limiting use of letters to those representing earned academic degrees should alleviate consumer confusion and more readily enable the consumer to identify members of the chiropractic profession.

The reproposed new rule will benefit licensees, in that they will be clearly advised of the Board's requirements in connection with practice identification so as to avoid charges of professional misconduct.

Economic Impact

The reproposed new rule should have no economic impact on the general public because it merely provides guidance as to the manner in which chiropractic licensees are to identify themselves for professional purposes.

Licensees who do not comply with the provisions of this rule may face whatever penalties or remedies the Board imposes on chiropractors whose actions have been deemed professional misconduct.

Regulatory Flexibility Analysis

If for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. chiropractors are deemed "small businesses" within the meaning of the statute, the following statement is applicable:

The reproposed new rule will apply to all of the approximately 3,000 current licensees of the Board of Chiropractic Examiners. Compliance with the rule involves no recordkeeping requirements, nor does it require the retention of professional services. However, the rule does involve the potential for a limited amount of once-only reporting since, upon request, a licensee must provide the Board with proof of having met the educational requirements. Nevertheless, such substantiation should be easily achieved, and there are no initial capital costs or other costs of compliance.

In essence, the reproposed new rule merely advises licensees of the manner in which they are to identify their practices for professional purposes. Since the intent of the rule is to create uniformity in the profession with regard to practice identification and to avoid consumer confusion, the reproposal must be applied uniformly without differentiation as to size of practice.

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

13:44E-2.6 [(Reserved)] **Practice identification**

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

1. "Certified" or "certifications" means that a licensee shall have fulfilled all requirements of the agency granting certification and shall have earned a certificate upon satisfactory completion of:

i. A program approved by the American Chiropractic Association (ACA), International Chiropractic Association (ICA) or the Federation of Straight Chiropractic Organizations (FSCO); or

ii. A program at a Board approved institution of chiropractic pursuant to N.J.S.A. 45:9-41.6; or

iii. A bona fide interdisciplinary program approved by the Board in an area of study that is within the scope of chiropractic in this State at a school, college or university.

2. "Diplomate" means that a licensee shall have attained diplomate status upon satisfactory completion of a program approved by ACA, ICA or FSCO or of a program at a Board approved institution of chiropractic, or of a bona fide interdisciplinary program at a Board approved school, college or university in an area of study that is within the scope of chiropractic in this State, and that the licensee shall have fulfilled all requirements of the agency granting diplomate status.

(b) A licensee of the Board of Chiropractic Examiners shall be identified for professional purposes (including, but not limited to, office identification, stationery, professional cards, signature on insurance claim forms, education, advertising, indoor and outdoor signs) in a manner clearly indicating the licensee's status as chiropractor by using the term chiropractor, doctor of chiropractic, chiropractic physician, or the abbreviation "D.C." as the degree actually conferred by a professional college. In any professional announcement, advertisement or other statement or communication placed before the public, the above-stated terms shall appear immediately adjacent to the full name of the licensee.

(c) The use of any letters immediately following the name of a licensee or elsewhere shall be deemed a representation of an earned academic professional degree or certification or diplomate status as defined in (a) above. A licensee shall not use any letters which represent non-academic degrees or certifications or abbreviations of membership in professional societies and associations which are not of certification or diplomate status as defined in (a) above.

(d) Any licensee who claims chiropractic certification or diplomate status in any advertisement shall have met all educational and other requirements set forth in (a) above. All such claims shall contain the full name of the agency, or the recognized abbreviation thereof, conferring the certification or diplomate, for example, Diplomate American Board Chiropractic Orthopedics. A licensee shall, upon request, provide the Board with substantiation of proper credentials to claim certification or diplomate status.

(e) The use of the term "Diplomate of National Board of Chiropractic Examiners" by a licensee in an advertisement shall be prohibited.

(f) Only those licensees who have achieved certification or diplomate status as defined in (a) above may use, in any advertisement, public announcement or other statement or communication placed before the public, any word or phrase (for example, "specialist") connoting that the licensee has advanced training and education. A licensee who has not achieved certification or diplomate status as defined in (a) above shall not use the term "specialist" or its substantial equivalent in any advertisement or other public statement but may use the term "limited to" if the licensee has adopted a voluntarily restricted scope of practice.

(g) The use of any word or phrase in an advertisement by a licensee connoting that the licensee emphasizes services within a particular area of the profession shall be preceded by the term "chiropractic," for example, "chiropractic orthopedics," "chiropractic sports injuries," "chiropractic neurology," etc.

(h) Any violation of the provisions of this section may be deemed professional misconduct.

(a)

DIVISION OF CONSUMER AFFAIRS OFFICE OF WEIGHTS AND MEASURES

Type Approval; Fees for the Registration, Inspection and Testing of Weighing and Measuring Devices

Proposed Amendment: N.J.A.C. 13:47B-1.5
Proposed New Rules: N.J.A.C. 13:47F

Authorized By: William J. Wolfe, Superintendent, Office of Weights and Measures.

Authority: N.J.S.A. 51:1-61, 51:1-129; P.L. 1994, c.60, §§6 through 13.

Proposal Number: PRN 1994-661.

Submit written comments by January 18, 1995 to:
William J. Wolfe, State Superintendent
Office of Weights and Measures
1261 Routes 1 and 9 South
Avenel, New Jersey 07001-1647

The agency proposal follows:

Summary

P.L. 1994, c.60 established and increased certain fees imposed by and on behalf of the State and provided for the use of those fees. These proposed new rules by the Office of Weights and Measures, N.J.A.C. 13:47F-1.1 through 1.7, are intended to establish registration procedures for commercial weighing and measuring devices and to establish fees for the registration and testing of those devices within certain limits set by the Act. The rules also establish procedures and fees for the testing of weights and measures which are not required to be registered. The rules describe the requirements for reimbursement and the mechanism for counties and municipalities with departments of weights and measures to be reimbursed. The rules additionally establish licensure requirements for and increases licensing fees of dealers and repairers of weights and measures described in N.J.S.A. 51:1-113 et seq.

One existing rule has been amended to clarify its intent: N.J.A.C. 13:47B-1.5 implements N.J.S.A. 51:1-93, which requires that all weights and measures devices sold or leased in the State meet the legal standard. The rule establishes the inspection and type approval procedure for sellers and lessors of weights and measures devices. Subsection (c) is amended to distinguish between the inspection and type approval required in order to sell a weight and measure device and the procedure for testing and sealing of a weight and measure, already purchased, to be found at N.J.A.C. 13:47F-1.4 in the proposed new rules.

A summary of each section of the proposed new rules is as follows:

N.J.A.C. 13:47F-1.1 describes the purpose and scope of the rules.

N.J.A.C. 13:47F-1.2 lists definitions of words considered to be essential to establish the operative intent of this subchapter.

N.J.A.C. 13:47F-1.3 establishes the procedures for registration and renewal of registration of weights and measures used in commerce in this State.

N.J.A.C. 13:47F-1.4 establishes the procedures for the testing and sealing of weights and measures, both for those used in commerce and for those not used in commerce.

N.J.A.C. 13:47F-1.5 describes the eligibility requirements for reimbursement to county and municipal weights and measures departments from the Weights and Measures Fund established under the Act.

N.J.A.C. 13:47F-1.6 establishes the procedures and requirements for licensure for those dealers and repairers of weights and measures described in N.J.S.A. 51:1-113 et seq.

N.J.A.C. 13:47F-1.7 presents the fee schedule.

Social Impact

The proposed new rules and amendment provide for improved protection for the public who use weighing and measuring devices while engaged in the buying or selling of commodities. The fees established by the Legislature in the Act are dedicated to the regulation of weights and measure devices. This enhanced oversight, which has been historically a function of the government, will help ensure that consumers are not cheated by the use of inaccurate or faulty weighing and measuring devices. Consumers benefit from devices which are accurate and in good repair. Merchants benefit from equity in the marketplace. These rules improve the State's ability to provide these benefits.

Economic Impact

The proposed new rules, N.J.A.C. 13:47F, and the proposed amendment of N.J.A.C. 13:47B-1.5(c) will have a negative economic impact upon the persons required to register the commercial weighing and measuring devices, persons who request tests of weighing and measuring devices from the State Superintendent of Weights and Measures, persons who engage in the business of selling, trading or repairing used weighing and measuring devices and persons who sell or lease commercial weighing and measuring devices. The State, county and municipal offices of Weights and Measures will also incur administrative costs of maintaining records of registration and testing of weighing and measuring devices in addition to the existing expenses of conducting the inspections and testing of weighing and measuring devices. In as much as these costs will vary depending upon the number, type and capacity of the devices, the economic impact of these rules cannot be readily quantified. While compliance with these rules will increase the cost of operating weighing and measuring devices, such increases are justified by the need to protect the public from being cheated by inaccurate weighing and measuring devices. The dedication of registration and testing fees to fund an enhanced program of regulation of weighing and measuring devices will provide for an effective program of safeguarding the interests of consumers in the market place.

The Legislature determined that fees raised from the registration and testing of weights and measures and deposited in a special fund are to be used for the costs of State regulation of weighing and measuring devices. The Act also requires reimbursements from the fund to be made to counties and municipalities with departments of weights and measures to defray all or part of their costs of operation. The Legislature established limits on fees to accommodate certain commercial locations. The funding mechanism allows for the regulation of weights and measures devices without the necessity for reliance on State budget appropriations. The benefit to the people of the State from the operation of accurate weighing and measuring devices far outweighs the burden of the costs imposed in commerce.

Regulatory Flexibility Analysis

The proposed new rules and amendment will apply to all businesses utilizing weighing and measuring devices for commercial purposes. The rules impose recordkeeping, reporting and other costs of compliance on the small business community (as "small business" is defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.). Owners and users of weighing and measuring devices used for commercial purposes will have to complete an application for the registration of all devices, pay the prescribed fees, affix the registration seals to the appropriate devices and have the Registration Certificate for the devices available for inspection, at the commercial location, by any Weights and Measures official. The State Office of Weights and Measures will have to provide the necessary administrative framework to maintain records of registration and testing of weighing and measuring devices. No professional services need be employed for compliance. The recordkeeping requirements are the minimum necessary to monitor compliance with the law; no lesser requirement or exemptions are provided based upon the size of business. The objectives of P.L. 1994, c.60, and these rules, in providing for an equitable marketplace for consumers, require uniform application to small business without regard to size. Consequently, no lesser requirement or exemptions is provided based upon the size of business, number of weighing and measuring devices or frequency of transactions.

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

13:47B-1.5 Type approval

(a)-(b) (No change.)

(c) No weighing or measuring device as indicated shall be permitted [in] **to be sold or leased for** use in the State of New Jersey unless submitted for inspection and approved by said State Superintendent of Weights and Measures as specified in [subsection] (a) [of this Section], **above** and any equipment distributed or installed

contrary to the provisions of this [Section] section shall be subject to condemnation.

CHAPTER 47F
[(RESERVED)]
FEES FOR THE REGISTRATION, INSPECTION AND TESTING OF WEIGHING AND MEASURING DEVICES

SUBCHAPTER 1. GENERAL

13:47F-1.1 Purpose and scope

(a) These rules implement the provisions of P.L. 1994, c.60, §§6 through 13, entitled "An Act establishing and increasing certain fees imposed by and on behalf of the State and providing for the use of certain fees, amending and supplementing various parts of the statutory law" (the "Act").

(b) These rules shall apply to:

1. Any person who operates or uses for commercial purposes a weight and measure, as defined in N.J.S.A. 51:1-2, located within the State;

2. Any person who sells, trades in, receives or engages in the repair of condemned, rebuilt or used weights and measures, pursuant to the provisions of N.J.S.A. 51:1-113 et seq.; and

3. Any person who requests a weight and measure not used for commercial purposes be compared with the standards of weights and measures in the custody of the State Superintendent of Weights and Measures.

13:47F-1.2 Definitions

For the purposes of this chapter, all definitions and terms describing weights and measures contained in N.J.S.A. 51:1-1 et seq. and in the National Institute of Standards and Technology Handbook 44, as adopted pursuant to N.J.A.C. 13:47B-1.20, are incorporated herein by reference. In addition, the following words and terms shall have the following meanings:

"Act" means P.L. 1994, c.60.

"Applicant" means a person who is an owner or user of a weight and measure.

"Commercial location" means the premises where weights and measures are installed or employed in the purchase or sale of commodities.

"Commercial purposes" means the purchase or sale of commodities.

"Fuel pump dispenser" means a device used for the measurement and sale of liquid fuels including, but not limited to, gasoline, diesel and kerosene, but not including liquefied petroleum gas and compressed natural gas.

"Length measure" means a device which automatically indicates (with or without value-computing capabilities) the length of commodities passing through the measuring elements.

"Natural gas meter" means a meter which is installed to measure compressed natural gas.

"Person" shall include any natural person or his or her legal representative, partnership, corporation, trust, business entity or association and any agent, employee, partner, office or director thereof.

"Pharmacy weight kits" means the set of weights required by N.J.A.C. 13:39-7.7.

"Propane meter" means a meter which is mounted on a liquefied petroleum gas delivery vehicle or installed at a fixed location to measure liquefied petroleum gas.

"Rack meter" means a meter used to load bulk delivery vehicles as in those primarily installed at wholesale petroleum terminals.

"Retail vehicle tank meter" means a meter mounted on a tank truck and used to deliver liquid fuel including, but not limited to, gasoline, diesel and kerosene with a maximum flow rate of 100 gallons per minute, but does not include meters used to sell or sell and deliver liquefied petroleum gas or compressed natural gas.

"State Superintendent" means the State Superintendent of the Office of Weights and Measures.

"Used in trade" means used for commercial purposes.

"Wholesale vehicle tank meter" means a meter mounted on a tank truck and used to deliver liquid fuels including, but not limtied to, gasoline, diesel and kerosene with a maximum flow rate of more than 100 gallons per minute, but does not include meters used to sell or sell and deliver liquefied petroleum gas or compressed natural gas.

13:47F-1.3 Registration of weights and measures

(a) No person shall operate or use a weight and measure for commercial purposes within the State of New Jersey unless the weight and measure is registered with the State Superintendent pursuant to the provisions of this chapter and the Act.

(b) An applicant for registration of a weight or measure shall submit an application on a form provided by the State Superintendent and shall pay the fee as set forth in N.J.A.C. 13:47F-1.7. The application form will request information including the legal name of the business, trade name and address and information about the type(s) of device(s), manufacturer's name, model number, capacity and serial number of the device(s). A late fee as set forth in N.J.A.C. 13:47F-1.7 for each weight and measure shall be incurred by an applicant if the application form and fee are not received by the State Superintendent within 30 days of the applicant's receipt of the application form.

(c) Upon the receipt of a completed application and the fee, the State Superintendent shall issue a Registration Certificate and registration seals for each weight and measure registered. The Registration Certificate and registration seals shall expire one year from the date of issuance.

(d) The applicant shall affix the registration seal to each registered weight and measure in a conspicuous location, without obscuring the official Approval Seal, and shall retain the Registration Certificate at the commercial location. If the weight and measure is located on a vehicle used for commercial purposes, the Registration Certificate shall be carried in the vehicle. The Registration Certificate shall be readily available for inspection by any Weights and Measures official.

(e) An applicant shall renew the Registration Certificate for one year by submitting a renewal registration application on a form provided by the State Superintendent and shall pay the appropriate renewal fees as set forth in N.J.A.C. 13:47F-1.7. The renewal application form will request the same information as required by (b) above. A late fee as set forth in N.J.A.C. 13:47F-1.7 for each weight and measure shall be incurred by an applicant if a renewal application and appropriate fees are not received by the State Superintendent within 30 days of the expiration date of the Registration Certificate.

(f) The late fee shall not be deemed an exclusive remedy for failure to register a weight and measure in a timely manner. Any unregistered weight and measure shall be deemed a violation of the Act.

(g) An applicant shall notify the State Superintendent in writing upon the purchase, sale or transfer of a weight and measure to a different commercial location within 10 days of the purchase, sale or transfer. The fee for the addition of a new weight and measure added to an existing registration shall be pro-rated for each quarter of the one year remaining of the renewal date on the initial Registration Certificate.

(h) Any violation of or noncompliance with any of the provisions of this chapter, for which a specific penalty has not been provided in Title 51 of the Revised Statutes, shall subject the violator to a penalty as prescribed by the provisions of N.J.S.A. 51:1-89.

13:47F-1.4 Testing and sealing of weights and measures

(a) All weights and measures used in trade shall be tested and sealed at least once in each year and shall be issued a Certificate of Inspection and Testing as described in N.J.A.C. 13:47B-1.16. All fees for testing and sealing of registered weights and measures shall be included within the fees for registration.

(b) Any applicant who requests a test of a weight and measure, not used for commercial purposes, tested by a Weights and Measures officer shall complete an application form provided by the State Superintendent and submit the same with appropriate fees

as set forth in N.J.A.C. 13:47F-1.7. Fees shall reflect those costs associated with causing the test to be made. The application form will request information about the applicant including name and address and information about the type(s) of device(s), manufacturer's name, model number, capacity, and serial number of the device(s), if any.

(c) The State Superintendent may at his or her discretion assign requests for a test of a weight and measure which is not used for commercial purposes to a county or municipal weights and measures officer.

13:47F-1.5 County and municipal weights and measures authority

(a) County and municipal weights and measures departments established pursuant to N.J.S.A. 51:1-42 et seq., under the supervision of the State Superintendent pursuant to the provisions of N.J.S.A. 51:1-54 et seq., shall be eligible to receive 70 percent of the fees collected for the registration, testing and sealing of the commercial weights and measures within their jurisdiction which are inspected and tested, providing that:

1. The inspection and testing of the registered weight and measure is performed by the county and municipal weights and measures department at least once a year;

2. The inspection and testing of weights and measures are conducted in conformity with the requirements and procedures specified in the most recent edition of the National Institute of Standards and Technology Handbook 44, together with all amendments and supplements thereto, adopted by the National Conference on Weights and Measures incorporated herein by reference; except that if the State Superintendent has amended or supplemented, in accordance with the provisions of N.J.S.A. 52:14B-1 et seq., any Handbook 44 requirements and procedures to conform to the needs of any situation affecting the interests of the State and its people, the county or municipal weights and measures department shall inspect and test the device(s) in accordance with the requirements and procedures as amended by the State Superintendent.

3. The weights and measures standards used by the county or municipality for testing the weights and measures have been compared to the State Standards in the custody of the State Superintendent and corrected and approved by the State Superintendent at least once in five years;

4. All certificates of inspections and tests of weights and measures shall be complete and correct in all respects;

5. Copies of certificates of inspections and tests of weights and measures, performed during the month, are submitted with a monthly report by the fifth day of the following month to the State Superintendent;

6. The weights and measures departments conduct their operations in compliance with State law and directives issued by the State Superintendent;

7. The governing bodies of the county and municipal weights and measures departments establish a "Weights and Measures Fund" as a non-lapsing, revolving, dedicated fund into which shall be deposited all reimbursement of fees received for inspection and testing of the weights and measures from the State Superintendent which shall be used to defray all or part of the expenses incurred in regulating weights and measures; and

8. The administrator or the finance officer of the governing bodies of the county and municipal weights and measures department shall submit a certification of the funds appropriated in their budget for weights and measures departments to the State Superintendent during the first quarter of the governing body's fiscal year. If there is any change in the amount of funds appropriated or supplemental appropriations are approved by the governing bodies, the administrator or the finance officer shall submit a supplementary certification to the State Superintendent within 30 days of the approval or the change.

(b) Copies of the National Institute of Standards and Technology Handbook 44 may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

(c) The State Superintendent shall disburse funds to county and municipal weights and measures departments by the end of the State fiscal quarter following the one in which the Certificates of Inspections and Tests for those weights and measures are received and approved by the State Superintendent.

(d) The State Superintendent shall have no obligation to a county and municipal weights and measures department for those fees due, but not collected, in any given quarter.

13:47F-1.6 Licensure requirements; dealers and repairers

(a) All persons engaged in the business of selling, trading in, receiving, or repairing of condemned, rebuilt, or used weights and measures, as described in N.J.S.A. 51:1-128, shall apply on a form provided by the State Superintendent for a Dealer's License and shall pay the fee as set forth in N.J.A.C. 13:47F-1.7. The application form will request information including the legal name of the dealer's business, trade name and address and information about the type(s) of device(s), manufacturer's name, model number, capacity, and serial number of the device(s) or testing equipment. All applications shall include a copy of the current Certificate of Inspections and Tests.

(b) All persons engaged only in the business of repairing of weights and measures, as described in N.J.S.A. 51:1-128, shall apply, on a form provided by the State Superintendent, for a Repairer's License and shall pay the fee as set forth in N.J.A.C. 13:47F-1.7. The application form will request information including the legal name of the repairer's business, trade name and address and information about the type(s) of device(s), manufacturer's name, model number, capacity, and serial number of the device(s) or testing equipment. All applications shall include a copy of the current Certificate of Inspections and Tests.

(c) All persons engaged in the business of selling, trading in, receiving, or repairing of condemned, rebuilt, or used weights and measures shall renew their license for a period of one year, by applying on a form provided by the State Superintendent and shall pay the renewal fee as set forth in N.J.A.C. 13:47F-1.7. The renewal application form will request the same information as required by (a) above. All renewal applications shall include a copy of the current Certificate of Inspection and Tests.

(d) All persons engaged only in the business of repairing of weights and measures shall renew their license for a period of one year, by applying on a form provided by the State Superintendent and shall pay the renewal fee as set forth in N.J.A.C. 13:47F-1.7. The renewal application form will request the same information as required by (b) above. All renewal applications shall include a copy of the current Certificate of Inspections and Tests.

(e) In addition to filing an application and submitting the same with a fee as set forth in N.J.A.C. 13:47F-1.7, all persons engaged in the business of repairing weights and measures, pursuant to the provisions of N.J.S.A. 51:1-113 et seq., shall have their weights and measures, including their testing equipment, compared with the State Standards in accordance with the requirements of the National Institute of Standards and Technology, formerly known as the National Bureau of Standards, Handbook 145, at least once a year.

(f) The State Superintendent shall issue a Certificate of Inspections and Tests upon compliance.

(g) Any violation of or noncompliance with any of the provisions of this section, for which a specific penalty has not been provided in Title 51 of the Revised Statutes, shall subject the violator to a penalty as prescribed by the provisions of N.J.S.A. 51:1-131.

13:47F-1.7 Fee schedule

(a) The State Superintendent shall charge the following Schedule of Fees for the Annual Registration, Inspection and Testing of Weights and Measures Used for Commercial Purposes and for the Inspection and Testing of Weights and Measures Not Used for Commercial Purposes:

Type of Device: Scales	Fee Per Device
Up to and including 1,000 pound capacity (other than hopper and vehicle scales	$20.00 per scale but not more than $200.00 per commercial location
More than 1,000 pound capacity (other than hopper and vehicle scales)	$100.00
Hopper scale	$200.00
Vehicle scale	$200.00
Wheel Load Weigher	$100.00
Belt Conveyor Scale System	$200.00
Automatic Bulk Weighing System	$200.00

Type of Device: Volumetric Meters	Fee Per Device
Fuel Pump Dispenser	$20.00 per dispenser hose but not more than $200.00 per commercial location
Retail Vehicle Tank Meter with a maximum flow rate of 100 gallons/minute	$40.00
Wholesale Vehicle Tank Meter	$200.00
Rack Meter	$200.00
Natural Gas and Propane Meter	$150.00
Mass Flow Meter	$200.00
Farm Milk Tank and Milk Meter	$200.00
Water Meter	$40.00

Type of Device: Miscellaneous	Fee Per Device
Length Measures	$20.00
Timing Devices	$10.00
Pharmacy Weight Kits	$20.00 per kit
Tuning Fork	$10.00
Volumetric Measure of less than or equal to 10 gallon capacity	$20.00
Volumetric Measure of more than 10 gallon capacity	$150.00
Timing Device	$10.00
Test Weights: less than 50 pounds	$10.00
Test Weights: equal to or more than 50 pounds	$30.00
Steel Tapes: less than or equal to 100 feet	
Tolerance Test	$20.00
Calibration Test	$100.00
Steel Tapes: longer than 100 feet	
Tolerance Test	$40.00
Calibration Test	$200.00
Any other device not listed above	$25.00
Late Fee	$10.00

NOTE: In addition to the above fees, hourly charges will be assessed at the rate of $50.00 per hour for testing of non-commercial devices not delivered to the State Superintendent.

(b) The State Superintendent shall charge the following Schedule of Fees for Licensure of Dealers and Repairers of Weights and Measures:

Dealer's license	$150.00
Repairer's license	$20.00
Dealer's license renewal	$150.00
Repairer's license renewal	$20.00

(a)

NEW JERSEY RACING COMMISSION

Harness Rules

Steward or Board of Judges Hearing; Finality of Decision Absent Appeal

Proposed Repeal and New Rule: N.J.A.C. 13:71-3.3

Authorized By: New Jersey Racing Commission, Frank Zanzuccki, Executive Director.

Authority: N.J.S.A. 5:5-30.

Proposal Number: PRN 1994-652.

Submit written comments by January 18, 1995 to:

Michael Vukcevich, Deputy Director
New Jersey Racing Commission
140 E. Front Street, CN 088
Trenton, New Jersey 08625

The agency proposal follows:

Summary

N.J.A.C. 13:71-3.3, prior to July 6, 1992, allowed for an appeal from Racing Commission Board of Judges hearings (harness racing) to the State Steward. The determination of the State Steward was then appealable to the Racing Commission. A July 6, 1992 amendment to N.J.A.C. 13:71-3.3 limited appeals to the State Steward of Board of Judges decisions involving "major suspensions" of 10 days or more. Suspensions of less than 10 days, imposed by the Board of Judges, as a result of that amendment, are presently appealed directly to the Racing Commission.

The Commission has found the July 6, 1992 amendment to be both administratively efficient and effective. The presently proposed repealed new rule would eliminate the possibility of any appeal of Board of Judges determinations, including "major suspensions," to the State Steward. Thus, as is the case pursuant to the Commission's thoroughbred rules and with respect to initial hearings presently conducted by the State Steward in harness racing, the appeal following an initial hearing conducted by the Board of Judges would be directly to the Commission. The Commission is of the view that elimination of a two-fold appeal process will not only save the Commission time and expense, and result in administrative convenience and flexibility, but will save licensees money in terms of time spent, attorney fees, etc. It is also considered practical in that the Board of Judges determinations are upheld through the Steward appeal procedure in the vast majority of cases. The proposed new rule will also result in the expedition of final case dispositions.

The proposed new rule clarifies and emphasizes that initial determinations of either the State Steward or Board of Judges are, subject to N.J.A.C. 13:71-1.23 (which authorizes the Commission to modify on its own motion any penalty or decision imposed pursuant to N.J.A.C. 13:71), final unless an appeal is filed with the Commission pursuant to N.J.A.C. 13:71-3.4 in writing and within three days of the date of imposition of the penalty. In accordance the existing state of affairs, the proposed new rule provides that any such appeal hearings conducted by the Commission shall be *de novo* proceedings conducted in accord are with the provisions of N.J.A.C. 13:71-3.5, which rule requires that such hearings be conducted pursuant to the Administrative Procedure Act, the Uniform Administrative Procedure Rules, and further, that the appeal hearing be expedited if a licensee has been suspended pending the hearing. The proposed new rule further provides that it is not to be construed so as to disallow the Commission from hearing matters and imposing disciplinary action directly, or from modifying any imposed penalty or decision. See N.J.A.C. 13:71-1.23 and 3.2.

Social Impact

As noted, the Commission is of the view that the elimination of a two-fold appeal process will save the Commission time and expense, result in administrative convenience and flexibility, and save licensees money in terms of time spent and attorney fees. The proposed new rule will also result in the expedition of final case dispositions. The rule will thus inure to the benefit of licensees and the Commission, by streamlining case dispositions in a manner consistent with the due process rights of Commission licensees. Some licensees, who file appeals to the State Steward in order to delay the imposition of an imposed suspension, may for this very reason, however, object to the proposal.

Economic Impact

The State Steward will have more time to devote to administrative and race-related matters as a result of the proposed amendment, thus indirectly saving the Commission time and expense. Additionally, because hearings are time consuming, the proposed new rule will save licensees time and money.

Regulatory Flexibility Statement

The proposed new rule imposes no reporting, recordkeeping or other compliance requirements on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed new rule establishes direct appeal to the Commission of State Steward or Board of Judges decisions, and clarifies the conduct of Commission hearings on such appeals. Therefore, a regulatory flexibility analysis is not required.

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

13:71-3.3 Steward[s] **or Board of Judges** hearing; **finality of decision absent appeal**

(a) [All appeals from decisions of the board of judges involving major suspensions of 10 days or more shall be considered by the State Steward. Such appeal hearing shall be a de novo proceeding and the steward may modify any penalty imposed by the board of judges upon notice and opportunity to be heard afforded the affected person or persons.] **Subject to N.J.A.C. 13:71-1.23, when the State Steward or Board of Judges conduct a hearing in the first instance with regard to the provisions of this chapter, the respective decision of the State Steward or Board of Judges shall be final unless an appeal, in accord with N.J.A.C. 13:71-3.1 and 3.4, is filed with the Commission. The appeal hearings of such matters shall be de novo proceedings conducted by the Commission in accord with N.J.A.C. 13:71-3.5.**

(b) [The decision of the State Steward shall be final unless an appeal is filed with the Commission.] **Nothing contained in this section shall in any way be construed to disallow the Commission from directly conducting a hearing with respect to the provisions of this chapter and directly imposing disciplinary action, or from modifying on its own motion any imposed penalty or decision.**

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Speed Limits

Route N.J. 45

Harrison Township, Gloucester County

Proposed Amendment: N.J.A.C. 16:28-1.96

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-98 and 39:4-198.

Proposal Number: PRN 1994-649.

Submit comments by January 18, 1995 to:

William E. Anderson
Manager
New Jersey Department of Transportation
Bureau of Traffic Engineering and Safety Programs
1035 Parkway Avenue
CN 613
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to amend N.J.A.C. 16:28-1.96 to revise certain "speed limit" zones along Route N.J. 45 in Harrison Township, Gloucester County, for the efficient flow of traffic, the enhancement of safety and the well-being of the populace.

Based upon a request of the local government of Harrison Township in Resolution No. 106-1994 adopted on August 1, 1994, and as part of a review of current conditions, the Department's Bureau of Traffic Engineering and Safety Programs conducted a traffic investigation. The investigation concluded that revising certain "speed limit" zones along Route N.J. 45 were warranted.

Appropriate signs shall be erected in areas where the speed limit zones have been changed.

Social Impact

The proposed amendment will establish a revised "speed limit" zone along Route N.J. 45, in Harrison Township Gloucester County, for the efficient flow of traffic, the enhancement of safety, and the well-being of the populace. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will bear the costs for the installation of "speed limit" zone signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed amendment does not place any reporting, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendment primarily affects the motoring public and the governmental entities responsible for the enforcement of the rules.

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

16:28-1.96 Route 45

(a) The rate of speed designated for the certain parts of State highway Route N.J. 45 described in this subsection shall be established and adopted as the maximum legal rate of speed:

1. For both directions of traffic:

i. (No change.)

ii. In Gloucester County:

(1) (No change.)

(2) Harrison Township:

(A) (No change.)

(B) Zone 2: 35 miles per hour between 350 feet south of New Street and [350 feet south of Colson Road] **the intersection of Route N.J. 45-Route N.J. 77** (approximate mileposts 16.98 to [18.35] **17.39**; thence

(C) Zone 3: 30 miles per hour between the intersection of Route N.J. 45-Route N.J. 77 and the northernmost intersection of Route N.J. 45-Route U.S. 322 (approximate mileposts 17.39 to 18.16); thence

(D) Zone 4: 35 miles per hour between the northernmost intersection of Route N.J. 45-Route U.S. 322 intersection and 350 feet south of Colson Road (approximate mileposts 18.16 to 18.35); thence

[(C)](E) Zone [3]5: 50 miles per hour between 350 feet south of Colson Road and the Harrison Township-Mantua Township corporate line (approximate mileposts 18.35 to 19.35); thence

(3)-(5) (No change.)

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Restricted Parking and Stopping
Route U.S. 30
Oaklyn Borough, Camden County
Proposed Amendment: N.J.A.C. 16:28A-1.21

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-198 and 39:4-199.
Proposal Number: PRN 1994-648.

Submit comments by January 18, 1995 to:
William E. Anderson
Manager
New Jersey Department of Transportation
Bureau of Traffic Engineering and Safety Programs
1035 Parkway Avenue
CN 613
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to amend N.J.A.C 16:28A-1.21 to establish no stopping or standing zones on Route U.S. 30 in Oaklyn Borough, Camden County. The provisions of this amendment will improve the flow of traffic and enhance safety along the highway system.

This amendment is being proposed at the request of the local government of the Borough of Oaklyn in Resolution No. 88-94 adopted on October 3, 1994, and as part of the Department's on-going review of current conditions. The traffic investigations conducted by the Department's Bureau of Traffic Engineering and Safety Programs concluded that the establishment of no stopping or standing zones along Route U.S. 30 were warranted. Signs are required to notify motorists of the restrictions proposed herein.

Social Impact

The proposed amendment will establish no stopping or standing restrictions zones along Route U.S. 30 in Oaklyn Borough, Camden County, to improve traffic flow and enhance safety. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will bear the costs for the installation of appropriate parking restriction zone signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed amendment does not place any reporting, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendment primarily affects the motoring public and the governmental entities responsible for the enforcement of the rules.

Full text of the proposal follows (additions indicated in boldface **thus**):

16:28A-1.21 Route U.S. 30

(a) The certain parts of State highway Route U.S. 30 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times.

1.-6. (No change.)

7. No stopping or standing in Oaklyn Borough, Camden County:

i. Westbound on the north side:

(1) Between East Haddon Avenue and the Oaklyn Borough—Collingswood Borough corporate line (approximate mileposts 5.13 to 5.44).

(b)-(c) (No change.)

(b)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Restricted Parking and Stopping
Route N.J. 173
Town of Clinton, Hunterdon County
Proposed Amendment: N.J.A.C. 16:28A-1.52

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-198 and 39:4-199.
Proposal Number: PRN 1994-647.

Submit comments by January 18, 1995 to:
William E. Anderson
Manager
New Jersey Department of Transportation
Bureau of Traffic Engineering and Safety Programs
1035 Parkway Avenue
CN 613
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to amend N.J.A.C 16:28A-1.52 to establish no stopping or standing zones on Route N.J. 173 in the Town of Clinton, Hunterdon County, between the hours of 4:00 P.M. and 6:30 P.M., except Saturdays, Sundays and holidays. The provisions of this amendment will improve the flow of traffic and enhance safety along the highway system.

This amendment is being proposed at the request of the local government of the Town of Clinton, Hunterdon County by Resolution No. 79-94 adopted on August 9, 1994, and as part of the Department's on-going review of current conditions. The traffic investigations conducted by the Department's Bureau of Traffic Engineering and Safety Programs concluded that the establishment of no stopping or standing zones along Route N.J. 173 were warranted. Signs are required to notify motorists of the restrictions proposed herein.

Social Impact

The proposed amendment will establish no stopping or standing restrictions zones between the hours of 4:00 P.M. and 6:30 P.M., except on Saturdays, Sundays and holidays along Route N.J. 173 in the Town of Clinton, Hunterdon County, to improve traffic flow and enhance safety. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The local government will bear the costs for the installation of appropriate parking restriction zone signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed amendment does not place any reporting, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The

proposed amendment primarily affects the motoring public and the governmental entities responsible for the enforcement of the rules.

Full text of the proposal follows (additions indicated in boldface **thus**):

16:28A-1.52 Route 173

(a) The certain parts of State highway Route 173 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs must be erected.

1.—5. (No change.)

6. No stopping or standing in the Town of Clinton, Hunterdon County:

i. Along the westbound (north) side: between 4:00 P.M. and 6:30 P.M., except Saturdays, Sundays and public holidays.

(1) Between at a point 35 feet west of the prolongation of the westerly curb line of Hancock Street to the Route I-78/U.S. 22 off-ramp (approximate milepost 13.15).

(b)-(c) (No change.)

(a)

NEW JERSEY TRANSIT CORPORATION

Use or Occupancy of NJ TRANSIT-Owned Property Proposed Readoption with Amendments: N.J.A.C. 16:77

Authorized By: New Jersey Transit Corporation, Shirley A. DeLibero, Executive Director.
Authority: N.J.S.A. 27:25-5(e), (h), (k) and 27:25-7(b).
Proposal Number: PRN 1994-639.

Submit comments by January 18, 1995 to:
Albert R. Hasbrouck, III, Senior Director Corporate Affairs
NJ Transit Corporation
One Penn Plaza East
Newark, New Jersey 07105-2246

The agency proposal follows:

Summary

The New Jersey Transit Corporation (hereinafter "NJ TRANSIT") was established by the New Jersey Public Transportation Act of 1979 (N.J.S.A. 27:25-1 et seq.) as the instrumentality of the State government responsible to establish and provide for the operation and improvement of a coherent public transportation system in the most efficient and effective manner. One of the programs by which NJ TRANSIT proposes to fulfill this responsibility is through the issuance of permits for certain fees to use its railroad right of way for various types of occupations. Permits are license agreements for the use and occupancy of railroad property by a utility, municipality or private entity. In accordance with the sunset provisions of Executive Order No. 66(1978), NJ TRANSIT proposes to readopt N.J.A.C. 16:77, Use or Occupancy of NJ TRANSIT-Owned Property, with amendments. This chapter is scheduled to expire on March 5, 1995.

The rules at N.J.A.C. 16:77 establish guidelines, procedures and fees pursuant to which NJ TRANSIT will operate its use or occupancy program. They have been in effect in essentially their present form since 1985. The proposed amendments primarily relate to what NJ TRANSIT believes are reasonable increases in the administrative and permit fees which have not been increased since 1990. As of September 1994, the cost of living has increased 18 percent since January 1990.

Increases for most individual fee line items range from 15 to 20 percent with an average just below the 18 percent cost of living increase.

A new proposed rule at N.J.A.C. 16:77-1.8 authorizes permanent occupancy permits for low value occupations for those applicants with a large number of occupancy permits. This is intended to reduce the administrative burden to both the applicants and to NJ TRANSIT.

Social Impact

The readoption of these rules will have a minimal social impact on the citizens of New Jersey as a whole but will specifically impact on the permittee who presently or may in the future occupy and use NJ TRANSIT property. Those parties affected will have to pay the fees set forth in the chapter, as increased by the proposed amendments.

Economic Impact

The proposed amendments to increase fees will have a positive impact on NJ TRANSIT. More revenues will be available to reduce the administrative costs to NJ TRANSIT to accommodate requests for occupancies thereby not increasing the deficits of its bus and rail operations. In addition, the impact on the users, especially the major utility companies, is considered minimal and it is anticipated that it can be borne by the parties in the ordinary course of business.

Besides the administrative and permit fees, the costs of application and meeting the permit conditions must be borne by the applicant/permittee. These costs vary based upon the nature of the use or occupancy of NJ TRANSIT-owned property. The economic impact of the proposed new rule at N.J.A.C. 16:77-1.8 which is permissive rather than mandatory, is considered negligible.

Regulatory Flexibility Analysis

Based on a review of NJ TRANSIT's current permits, very few small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., will be impacted by the proposed readoption with amendments. If any are affected, the compliance requirements consist of applying for a permit under N.J.A.C. 16:77-1.2, meeting the N.J.A.C. 16:77-1.3 permit conditions, and payment of the appropriate administrative and permit fees. Compliance with the permit conditions will involve both capital costs and, probably, the engaging of professional services (for example, engineers and attorneys). The amount of such costs depends upon the nature of the project and the permittee's internal staff resources. Given the historic lack of small business applicants/permittees, NJ TRANSIT has not provided different requirements for such entities. In addition, no apparent correlation exists between the need for compliance with these rules to ensure the safe and proper use of NJ TRANSIT-owned property and the business size of an applicant/permittee.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at 16:77.

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

16:77-1.1 Definitions

The following words and terms, as used in this chapter, shall have the following meanings:

...

"Longitudinal occupation" means any occupation of NJ TRANSIT-owned property other than a direct crossing over or under railroad tracks and right-of-way as defined under N.J.A.C. 16:77-[1.6]**1.7**.

...

"Messenger wires" means any support wire which carries no current, signal or communication transmission and **has a specific purpose to assist in installing, servicing and replacing overhead occupancies. Messenger wires** shall be considered as part of the wires or cables supported and no charge shall be assessed therefor.

"Municipality" means a local governing body such as a borough, township, city or village.

"NJ TRANSIT-owned property" means railroad property in the State of New Jersey, [or] New York **and Pennsylvania** owned and/**or** operated by NJ TRANSIT regardless of **the** operating agent **or active status of the railroad.**

...

"Transverse occupation" means that part of any overhead or under-grade line which crosses a track or tracks [of the NJ TRANSIT-owned railroad within the limits of that portion of its right-of-way intended for railroad purposes] **or any NJ TRANSIT-owned right-of-way**.

...

16:77-1.2 Permit applications

(a) No person may use or occupy NJ TRANSIT-owned property without obtaining a permit from NJ TRANSIT. All requests for permits shall be submitted [by letter] **in writing** and addressed to:

[New Jersey Transit Corporation
Department of Property Management and Development
McCarter Highway and Market Street
P.O. Box 10009
Newark, New Jersey 07101]

NJ TRANSIT
Real Estate Division
Manager, Property Management—Permits
One Penn Plaza East
Newark, New Jersey 07105-2246

(b)-(e) (No change.)

(f) If **at any time** the permittee seeks to modify its use or occupancy of the NJ TRANSIT-owned property [during the term of the permit], the permittee shall be required to apply for a new permit according to the provisions of this section.

(g) (No change.)

16:77-1.3 Permit conditions

(a)-(g) (No change.)

(h) NJ TRANSIT assumes no obligations whatsoever in connection with the use, work, and/or occupancy by the permittee and is not obligated to make any repairs to the property or furnish [men] **people**, equipment or materials in connection with use, work and/or occupancy by the permittee. The use, work, and/or occupancy provided for by the permit shall be performed at no cost to the involved jurisdiction.

(i)-(n) (No change.)

16:77-1.4 Administrative fees

(a) Administrative fees will be charged as follows:

1. Wire and cable crossings and longitudinal occupations over or under NJ TRANSIT-owned property:

i. [Not] **All transverse crossings not** exceeding 300 volts to one individual service ..... [$125.00] **$145.00**

ii. All other transverse crossings ..... [$250.00] **$295.00**

iii. All longitudinal occupations and any **other** agreement **not already identified in this section,** regardless of voltage[, not less than] ..... [$500.00] **$600.00**

2. Pipe and sewer crossings, and longitudinal occupations over or under NJ TRANSIT-owned property:

i. Pipe not exceeding [3] **three** inches inside diameter to one individual service ..... [$125.00] **$145.00**

ii. All other transverse crossings ..... [$250.00] **$295.00**

iii. [All] **Any** longitudinal occupation[s and any agreement regardless of size of pipe, not less than ..... $500.00] **requiring more than one field excursion by NJ TRANSIT personnel shall be charged an additional $100.00 for every outing beyond the single outing allotted each application.**

3. All surface drainage not contained within a pipe **and** occupying NJ TRANSIT property ..... [$500.00] **$590.00**

[4. Short term or occupancy:

i. Application for the use or occupancy of track, trains, or property which will require the alteration of track usage or train schedules $315.00

ii. Application for the use or occupation of NJ TRANSIT-owned property not covered by (a)4i above ..... $125.00]

[5.]**4.** Any application for any type of permit by a municipality ..... [$125.00] **$145.00**

[6.]**5.** Additional fees:

i.-ii. (No change in text.)

16:77-1.5 Permit fees: general conditions

(a) Long term use or occupancy permit fees are subject to the following conditions:

1. (No change.)

2. The minimum annual permit fee under any application shall be [$125.00] **$145.00**.

[3. Any permit generating an annual occupancy fee of less than the minimum per annum fee of $125.00 will be assessed an annual document maintenance fee of $50.00. This fee is in addition to the calculated annual occupancy fee. Document maintenance fees will be paid in advance for the same number of years as the prepaid occupancy fee.]

[4.]**3.** Should the facility be terminated at any time less than the estimated years of occupancy, the fees collected are not subject to a refund [for any permit less than the estimated years of occupancy. (Minimum 1 year-maximum 20 years)].

[5.]**4.** NJ TRANSIT reserves the right to consider additional fees [or] **for** crossings in excess of 200 feet. When increased preparation costs are incurred, the increases will be passed on to the permittee.

[6.]**5.** (No change in text.)

[7.]**6.** Fees are based on a minimum right-of-way width of 30 feet with [a fee] **the annual rate** applicable **up** to a 200 foot width. For all crossings in excess of 200 linear feet, a per foot charge [at the applicable 30 foot rate] will be assessed, **for each foot in excess of 200 linear feet. The per foot rate will be established through the use of the applicable 30 foot rate. Any facility crossing exceeding 400 linear feet will be assessed an annual fee as described above for the first 400 linear feet. The remainder (that which is in excess of the first 400 linear feet) will be calculated as if it were a longitudinal facility. Example:** [that is,] the annual fee for a [300 L.F.] **620 linear foot** transverse occupancy, [with an annual occupancy fee of $120.00 for the first 200 L.F., would be calculated as follows: (300 feet—200 feet) ($120.00 divided by 30) + $120.00 = fee.] **would be calculated using the following formula:**

First 200 LF: ..... x = base rate
Second 200 LF: ..... y = (Base crossing fee ÷ 30) Multiplied by 200
Remaining LF: ..... z = longitudinal fee ÷ 4
Add all components (x + y + z) to establish the annual fee.

[8.]**7.** (No change in text.)

[9.]**8.** Should the facility be modified during the term of the permit, **during the processing of a** new permit, or **there is a** supplement to [the] **an** existing permit, the associated increase in fees will be charged. If a new permit is approved, an amount proportionate to the time remaining on the superseded permit will be credited toward the new fee.

Recodify existing 10.-11. as **9.-10.** (No change in text.)

(b) An annual occupancy fee for attachments will be charged as follows when higher rates are not fixed:

1. Attachments of aerial wires and cables to poles or other structures of NJ TRANSIT-owned facilities used in wire line construction:

i. Up to and including 32,500 volts for each attachment to NJ TRANSIT-owned cross-arms or brackets ..... [$7.00] **$8.00**

ii. Up to and including 32,500 volts for each attachment to (licensee's) permittee's cross-arms or brackets when [they] **those brackets** are attached to a NJ TRANSIT-owned facility ..... [$5.00] **$6.00**

iii. Wires over 32,500 volts attached to the NJ TRANSIT-owned cross-arms or brackets ..... [$12.00] **$14.00** per attachment

iv. Wires over 32,500 volts and attached to (licensee's) permittee's cross-arms or brackets when those brackets are attached to NJ TRANSIT-owned facilities ..... [$10.00] **$12.00** per attachment

2. Attachments of aerial wires and cables to buildings or other structures:

i. Each wire or cable attached to railroad **owned** bridges or structures, including railroad or highway bridges [$12.00] **$14.00** per attachment

3. Attachments of cable terminals to poles, buildings, or structures, including highway bridges[,] **and** railroad bridges owned by NJ TRANSIT:

i. Each cable terminal, loading coil, transformer, or like device is subject to special consideration in each case, but not less than [$45.00] **$53.00**

4. Pipelines carried along NJ TRANSIT-owned property on bridges or other supports are subject to special consideration in each

case if permitted by current New Jersey Department of Transportation specifications.

5. (No change.)

(c) An annual occupancy fee for guy wire crossings and overhanging cross-arms and power wires and cables of transmission lines outside of NJ TRANSIT-owned right-of-way will be calculated as follows:

1. Each guy wire crossing NJ TRANSIT-owned property but not anchored thereon ..... [$7.00] **$8.00**

2. Cross-arms overhanging NJ TRANSIT-owned property from poles located outside thereof, one or more cross-arms on any pole ..... [$5.00] **$6.00**

3. (No change.)

[(d) In any event, if a permit fee is determined to be less than the minimum $125.00 annual fee, the duration of the permit will be extended to whatever multiple is necessary to achieve the minimum fee.]

[(e)]**(d)** (No change in text.)

[(f)]**(e)** The minimum permit fee under any agreement where a miscellaneous use of occupancy is involved, not previously defined, shall be [$125.00] **$145.00**. The applicant may be subject to possible charges which may result from expenses incurred by NJ TRANSIT's subsidiaries or involved jurisdictions. (NOTE: Permit fees for miscellaneous use or occupancy of NJ TRANSIT-owned property will be determined and charged on an individual basis because of the various types of requests.)

[(g)]**(f)** (No change in text.)

[(h)]**(g)** Short-term use [on] **or** occupancy fees are subject to the following conditions.

1. (No change.)

2. The minimum permit fee under any application shall be [$125.00] **$145.00**.

3.-6. (No change.)

16:77-1.6 Permit fees: transverse occupation

(a) All fees in this section are based on a minimum right-of-way width of 30 feet, with a fee applicable up to a 200 foot width. For all crossings in excess of 200 feet, [a per foot charge at the applicable 30 foot rate will be assessed (see example N.J.A.C. 16:77-1.5(a)7)] **an adjustment in the annual fee will be assessed and calculated in accordance with the example contained within this schedule under N.J.A.C. 16:77-1.5(a)7.**

(b) Aerial and underground wire (power and communication) crossings not exceeding 200 feet in length will be charged an annual occupancy fee as follows:

1. Power:

i. All crossings up to but not exceeding 6,900 volts [$125.00] **$145.00**

ii. Over 6,900 volts but not exceeding 32,500 volts [$225.00] **$265.00**

iii. Over 32,500 volts but not exceeding 50,000 volts [$375.00] **$440.00**

iv. Over 50,000 volts but not exceeding 345,000 volts [$500.00] **$590.00**

v. Over 345,000 volts but not exceeding 500,000 volts [$750.00] **$880.00**

vi. Over 500,000 volts ..... [$1,000.00] **$1,175**

vii. Ducts or pipes carrying conductors ..... No Charge

viii. Manholes (each) ..... [$65.00] **$75.00**

(NOTE: Attachments of wires, cables, etc. to bridges, buildings, poles or structures of railroad **are** subject to special consideration in each case. Crossings of right-of-way by pipe type cable consisting of one or more high voltage cables encased in a steel pipe, under inert oil pressure and/or further encases in a larger steel pipe and the space between the pipes filled with compacted **or thermal** sand [should] **will** be subject to special consideration and each case **will be** handled individually.)

2. Communication:

i. Telephone and other communication cables (not including composite coaxial cables **or fiberoptic cables**):

(1) Cable containing not more than 500 pairs [$125.00] **$145.00**

(2) Cable containing 501 to 1100 pairs ..... [$220.00] **$255.00**

(3) Cable containing 1101 to 1800 pairs ..... [$315.00] **$370.00**

(4) Cable containing over 1800 pairs ..... [$500.00] **$590.00**

ii. Composite coaxial cables and coaxial television cables containing not more than [4] **four** conductors ..... [$185.00] **$215.00**

iii. All cables containing over four conductors shall be at a rate of [$25.00] **$30.00** for each additional conductor.

3. Fiberoptics:

i. [All fiberoptics installations will be charged through a negotiated fee.] **Fiberoptic cable crossings used for long distance telephone and data transmission and for retail distribution to more than 500 households and/or retail businesses $1,500**

ii. Fiberoptic cable crossings used for retail distribution to 500 or less than 500 households and/or retail businesses ... $800.00

(c) Poles, towers, guys, and anchors and spare ducts or pipes will be charged an annual fee as follows:

1. Single wooden pole (per pole) ..... [$30.00] **$35.00**

2. All other supporting structures other than the auxiliary facilities and appurtenances listed in (c)3, 4, 5, 6, 7, and 8 below [$60.00] **$70.00**

3. Each brace, stub pole, or anchor ..... [$30.00] **$35.00**

4. Each guy anchored on or crossing NJ TRANSIT-owned [railroad] property $7.00

5. All towers, if not included in a longitudinal occupation shall be assessed per tower leg at ..... [$40.00] **$45.00**

6. Each span guy wire crossing ..... [$30.00] **$35.00**

7. Spare or unoccupied ducts or pipes, each (when the duct shall be occupied in the future by a cable, the annual fee **for the facility occupying the duct** shall govern and the [$30.00] **$35.00** charge cease) ..... [$30.00] **$35.00**

8. Guys, stubs, anchors, and push or pull braces required by specification for the support of a crossing pole on NJ TRANSIT-owned right-of-way **and** at the request of [the] NJ TRANSIT[-owned] shall be considered as part of the crossing pole and no charge **will be** made therefore.

(NOTE: The above charges in (c)1-8 **above** are in addition to the wire and cable occupation charges provided in (b)1-3 above.)

(d) Annual permit occupancy fees for pipes and sewer crossings not exceeding 200 feet in length will be calculated as follows:

1. Circular lines carrying no pressure:

i. Pipes up to and including 12 inches ID . [$125.00] **$145.00**

ii. Pipes over [122] **12** inches and not exceeding 24 inches ID ..... [$170.00] **$200.00**

iii. Pipes over 24 inches and not exceeding 60 inches ID will be charged at a rate of [$5.00] **$6.00** per inch of ID over the first 24 inches. This rate is in addition to a minimum fee of [$185.00] **$215.00**

iv. Pipes over 60 inches ID will be charged at a rate of [$2.50] **$2.75** per inch of ID over the first 60 inches. This rate is in addition to a minimum fee of ..... [$375.00] **$440.00**

2. Circular lines under pressure and carrying non-flammable, non-explosive, or non-combustible supporting materials, except coal and water slurry:

i. Pipes up to and including 12 inches ID . [$150.00] **$175.00**

ii. Pipes over 12 inches but not exceeding 24 inches ID [$190.00] **$220.00**

iii. Pipes over 24 inches ID and not exceeding 60 inches ID will be charged at a rate of [$7.00] **$8.00** per inch of ID over the first 24 inches. This rate is in addition to a minimum fee of [$190.00] **$220.00**

iv. Pipes over 60 inches ID will be charged at a rate of [$5.00] **$6.00** per inch of ID over the first 60 inches. This rate is in addition to a minimum fee of ..... [$400.00] **$470.00**

3. Circular lines under pressure and carrying flammable, explosive, or combustible supporting materials, except coal and water slurry:

i. Pipes not exceeding three inches inside nominal diameter—minimum charge for any one crossing ..... [$185.00] **$215.00**

ii. Pipes over three inches inside nominal diameter and not exceeding 12 inches inside diameter—minimum charge for any one crossing ..... [$250.00] **$295.00**

iii. Pipes over 12 inches inside diameter and not exceeding 24 inches inside diameter shall be charged at a rate of [$12.00] **$14.00** per inch of ID over the first 12 inches. This rate is in addition to a minimum charge for any one crossing of [$250.00] **$295.00**

iv. Pipes exceeding 24 inches in **inside** diameter shall be charged at a rate of [$13.00] **$15.00** per inch of ID over the first 24 inches. This is in addition to a minimum charge for any one crossing of [$400.00] **$470.00**

4.-6. (No change.)

7. Manholes (each) ..... [$60.00] **$70.00**

8.-9. (No change.)

16:77-1.7 Permit fee: longitudinal occupations

(a)-(b) (No change.)

(c) The following charges cover the complete transmission line occupation and additional charges are not to be made unless there are attachments to NJ TRANSIT-owned facilities. For the purpose of determining voltage, guy wires, messengers and grounded conductors shall be considered as zero voltage. All other conductors shall be rated at voltage to other conductors, whichever is higher.

1. Aerial wires:

i. Transmission line, highest voltage not exceeding 6,900 volts [$1,250] **$1,465** per circuit per mile.

ii. Transmission line over 6,900 volts up to [but not] **and** including 32,500 volts ..... [$2,250] **$2,640** per circuit per mile.

iii. Transmission line 32,500 volts, up to and including 50,000 volts [$3,125 per circuit mile] **$3,670 per circuit per mile.**

iv. (No change.)

2. Aerial and underground cables:

i. All longitudinal fiberoptic facility occupancy fees will be arrived at through negotiations.

[i.]**ii.** Telephone communication cables (not including composite coaxial cables):

(1) Cable containing not more than 1,100 pairs [$1,250] **$1,465** per cable per mile.

(2) Cable containing 1,101 to 1,800 pairs [$2,250 per cable mile] **$2,640 per cable per mile.**

(3) Cable containing over 1,800 pairs: The fee will be negotiated at a rate not less than [$2,250] **$2,640** per cable **per** mile.

(4) For underground communication cables the minimum charge is [$2,500] **$2,935** per cable per mile.

[ii.]**iii.** Composite coaxial cable and coaxial television cables **are** subject to negotiation but not less than ... [$3,125 per mile] **$3,570 per cable per mile.**

[iii.]**iv.** Underground power cables:

(1) When **a** cable is buried in an open trench and covered with soil: [Minimum charge $1,800] **$2,115** per circuit per mile.

(2) When **a** cable is buried in an open trench and surrounded with from 6 to 12 inches of thermal sand: [Minimum charge $3,125] **$3,670** per circuit per mile.

(3) When **a** cable is encased in a steel pipe under inert oil pressure and/or further encased in a larger steel pipe and the space between the pipes filled with compacted sand: [$7.00] **$8.00** per inch of nominal diameter of the largest pipe per 100 feet of occupation or fraction thereof [with a minimum charge of 3,125 per mile] **$3,670 per cable per mile.**

[iv.]**v.** Spare or unoccupied ducts or pipes, each per mile [$375.00] **$440.00**

[v.]**vi.** Manholes, splicing chambers [on] **or** pull boxes, each when these structures are necessary for longitudinal occupation No Charge

[vi.]**vii.** An additional charge shall be made for use of NJ TRANSIT-owned property duct lines based on the **negotiated** value of the facility.

(NOTE: Charges shown under [(c)2iv, v and vi,] **(c)2v, vi and vii** above are in addition to the charges shown under [i to iii] **(c)2ii to iv above** inclusive.)

(d) (No change.)

(e) All structures other than manholes will be charged based through their own individual negotiations. Examples of these structures are meter chambers, siphon chambers, substations, pump stations, **well sites, towers,** etc.

(f) An annual occupancy fee for pipes and sewers will be charged as follows:

1. Circular lines carrying no pressure: [$2.50] **$3.00** [minimum charge] per inch of inside nominal diameter or fraction thereof per 100 feet of occupation or fraction thereof.

2. Circular lines under pressure and carrying non-flammable, non-explosive, and non-combustible supporting materials, except coal and water slurry: [$3.00] **$3.50** [minimum charge] per inch of inside nominal diameter per 100 feet of occupation or fraction thereof.

3. Circular lines under pressure and carrying flammable, explosive, and combustible supporting materials, and coal and water slurry: [$7.00] **$8.00** [minimum charge] per inch of inside nominal diameter per 100 feet of occupation or fraction thereof.

4.-5. (No change.)

[16:77-1.8 Automatic annual fee increases

All of the fees set forth in this subchapter shall be increased five percent each year on the anniversary date of the readoption of these rules, (March 5) rounded up to the nearest five dollars ($5.00).]

16:77-1.8 Other provisions

(a) For those applicants having over 200 occupancy permits with NJ TRANSIT, the Corporation reserves the right to negotiate permanent occupancy permits for any occupancy having an annual fee of $300.00 or less at the time of application. The permittee shall pay to NJ TRANSIT a lump sum which will be equivalent to 16 times the annual rate which will satisfy the annual fee for the life of the facility occupation so long as it remains unchanged. No refunds will be given for any facility which is terminated, cancelled, removed, or abandoned. Permittees who qualify for this option, request such option and are accepted by NJ TRANSIT, will receive a single "blanket agreement" with an attachment containing a list of the affected occupancies covered under individual permits. Acceptance of any request for a blanket agreement and lump sum payment will be at the sole discretion of NJ TRANSIT which shall not be unreasonably exercised. The existence of this option does not obligate NJ TRANSIT to enter into a blanket agreement with any permittee.

(b) Any facility which is altered in such a manner so as to increase the annual fee beyond the original $300.00 limit will result in that permit being extracted from the blanket agreement and a new annual fee will be calculated, based on the existing fee schedule, and assessed annually thereafter. Monetary credit will be allocated to the new facility fee based on the unused portion of the initial 16 year period. No credit will be given for any facility requiring reassessment which has exceeded the initial 16 years of occupancy.

TREASURY-TAXATION

(a)

DIVISION OF TAXATION

Organization of the Division of Taxation Warrants

Proposed New Rule: N.J.A.C. 18:1-2.4

Authorized By: Richard D. Gardiner, Director, Division of Taxation.

Authority: N.J.S.A. 54:50-1 and 54:49-13a.

Proposal Number: PRN 1994-632.

Submit comments by January 18, 1995 to:

Nicholas Catalano
Chief, Tax Services
Division of Taxation
50 Barrack Street
CN-269
Trenton, NJ 08646

The agency proposal follows:

Summary

The proposed new rule explains a procedure in which the Division will issue warrants by mail. N.J.S.A. 54:49-13a authorizes the Division

to issue warrants to levy on and sell the assets of any person liable for any State tax. The warrant may be issued to the sheriff of a county commanding the sheriff to levy on the taxpayer's property.

Under N.J.S.A. 54:49-13a, warrants may also be executed in the Director's discretion by officers or employees of the Division of Taxation. Officers and employees of the Division are given all the powers conferred by law on sheriffs.

N.J.S.A. 54:49-13a does not specify a means for delivery of warrants. The current procedure is for Division employees to personally carry warrants to banks for the purpose of levying on taxpayer assets.

Metromedia, Inc. v. Director, Division of Taxation, 97 *N.J.* 313 (1984), requires agencies to promulgate rules to notify the public of a proposed change in policy. In compliance with that mandate the Division proposes a new rule which interprets N.J.S.A. 54:49-13a to allow the Division to mail warrants to banks, rather than send Division employees to hand deliver them. Banks would be authorized to accept the warrants received by mail from the Division, and levy on assets of taxpayers liable for State taxes.

Social Impact

The proposed new rule is intended to simplify and explain the procedure by which the Division issues warrants to levy on the assets of taxpayers liable for State taxes. Banks would be notified that they may accept warrants of execution received by mail from the Division and that it is not necessary for warrants to be delivered in person by Division employees. The impact of the proposed rule on taxpayers would be negligible, since the Division is already authorized by N.J.S.A. 54:49-13a to issue and execute warrants.

Economic Impact

The proposed new rule is intended to provide efficiency in the procedure for delivery and execution of warrants on the assets of taxpayers with outstanding tax liabilities. Under the proposed new rule, the Division would no longer send personnel to banks solely to deliver warrants of execution for the purpose of executing on taxpayer assets, but instead would utilize the postal service for delivery of the warrants.

Regulatory Flexibility Analysis

The proposed new rule relates to a procedure involving the delivery of warrants of execution to levy on assets of taxpayers with tax liabilities. The rule could affect small businesses with delinquent tax liabilities in the sense that the rule describes a procedure by which the Division may deliver warrants of execution on the small business's assets. However, under N.J.S.A. 54:49-13a, the Division may issue warrants of execution to levy on assets of both small and large businesses with outstanding tax liabilities regardless of whether the rule is adopted. The rule should not necessitate the hiring of professional tax advice by small businesses since the rule does not affect the size or determination of tax liabilities.

Full text of the proposed new rule follows:

18:1-2.4 Warrant to levy and sell real and personal property

(a) The Director is authorized by N.J.S.A. 54:49-13a to issue a warrant, directed to the sheriff of any county, commanding him to levy upon and sell the real and personal property of any person liable for any state tax.

(b) In the discretion of the Director, a warrant may be issued and directed to any officer or employee of the Division of Taxation, and in the execution thereof such officer or employee shall have all the powers conferred by law upon sheriffs to levy upon assets of any person liable for any State tax and to seize and sell property of the debtor at public auction. The warrant may be issued and executed in person or by mail.

(c) See N.J.S.A. 54:49-13a for information on collection procedures.

(a)

DIVISION OF TAXATION

Corporation Business Tax
Employer Trip Reduction Program Tax Credit
Proposed New Rule: N.J.A.C. 18:7-3.19

Authorized By: Richard D. Gardiner, Director, Division of Taxation.

Authority: N.J.S.A. 54:10A-27 and 27:26A-15.

Proposal Number: PRN 1994-640.

Submit comments by January 18, 1995 to:

Nicholas Catalano
Chief, Tax Services
Division of Taxation
50 Barrack Street
CN-269
Trenton, NJ 08646

The agency proposal follows:

Summary

P.L. 1993, c.150, approved June 24, 1993, provides an employer tax credit as an incentive for compliance with the "New Jersey Traffic Congestion and Air Pollution Control Act," P.L. 1992, c.32 (N.J.S.A. 27:26A-1 et seq.). The credit is against the Corporation Business Tax and other taxes enumerated in P.L. 1993, c.150 (N.J.S.A. 27:26A-15).

The credit is available to employers who have been certified by the Department of Transportation to have registered and received approval for a transportation "compliance plan" under N.J.S.A. 27:26A-5. The bill authorized the Commissioner of the Department of Transportation to propose rules explaining the operation of the credit. The Department of Transportation has proposed rules N.J.A.C. 16:50-15 at 26 N.J.R. 757(a). The present proposed new rule, N.J.A.C. 18:7-3.19, is intended to alert taxpayers and tax practitioners to the existence of the credit and to consult N.J.A.C. 16:50-15 for information about how to qualify for the credit and how the credit is calculated.

For corporation business tax purposes, the credit is claimed by completing Form 307 and attaching it to the Corporation Business Tax return being filed.

Social Impact

The social impact of the proposed new rule will be beneficial in that the rule will alert taxpayers to a credit against the Corporation Business Tax enacted by P.L. 1993, c.150. The credit is expected to provide employers subject to the Corporation Business Tax and other taxes with an incentive to comply with P.L. 1992, c.32, N.J.S.A. 27:26A-1 et seq., the New Jersey Traffic Congestion and Air Pollution Control Act, enacted to address environmental concerns arising from traffic. The reaction to the rule should be positive because the rule incorporates the credit into the Corporation Business Tax rules, thereby providing guidance to employers and their advisors on the operation of the credit.

Economic Impact

The enactment of this credit was anticipated to annually reduce State revenues by an amount in the range of 12 to 16 million dollars for the first full fiscal year and 20 to 30 million dollars for each fiscal year thereafter, according to the Senate Budget and Appropriations Committee Statement. Revenue losses were expected to depend on levels of activity and the provision of employee commuter transportation benefits at the time.

Employers subject to the Corporation Business Tax would benefit by having their tax liability reduced to the degree they are able to utilize the credit, which depends upon their providing employee transportation benefits under N.J.S.A. 27:26A-5 et seq. and upon the statutory limits on the credit itself, as outlined in proposed rules at N.J.A.C. 16:50-15.

Regulatory Flexibility Analysis

The proposed new rule could apply to any taxpayers subject to the Corporation Business Tax, including incorporated small businesses, as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. However, the proposed rule does not impose reporting or recordkeeping requirements; the only compliance requirement is that a completed Form 307 be attached to the Corporate Business Tax return to claim the credit. The rule will make employers aware of the existence of a credit against the Corporation Business Tax, enacted in P.L. 1993, c.150, available to employers who provide certain commuter transporta-

tion benefits to their employees, as described at proposed N.J.A.C. 16:50-15.

Large and small corporate taxpayers may wish to obtain the services of accounting or legal professionals, charging at normal rates, to determine if the corporation may take advantage of the credit. The rule implements a credit which would reduce the Corporation Business Tax and thus has the potential to benefit small businesses subject to the tax.

Full text of the proposed new rule follows:

18:7-3.19 Employer trip reduction program tax credit

(a) Corporate taxpayers are allowed a credit under N.J.S.A. 27:26A-15 for the cost of commuter transportation benefits provided to employees. See N.J.A.C. 16:50-15 for information on the employer trip reduction program tax credit.

(b) The taxpayer may only claim a credit for providing commuter transportation benefits based upon a direct expenditure made after the taxpayer has registered with the Department of Transportation as prescribed in N.J.S.A. 27:26A-5. For the purposes of verifying eligibility for the credit, the Director of the Division of Taxation will compare the claim with a list of those employers certified by the Commissioner of the Department of Transportation to have registered with the Department of Transportation or have an approved compliance plan or an approved amended compliance plan.

(c) To claim the credit, the taxpayer must complete Form 307 and attach it to the Corporation Business Tax return (Form CBT-100 or CBT-100S) being filed.

(a)

DIVISION OF TAXATION

Sales and Use Tax

Student Organization Purchases

Proposed New Rule: N.J.A.C. 18:24-9.13

Authorized By: Richard D. Gardiner, Director, Division of Taxation.

Authority: N.J.S.A. 54:50-1.

Proposal Number: PRN 1994-633.

Submit comments by January 18, 1995 to:

Nicholas Catalano
Chief, Tax Services
Division of Taxation
50 Barrack Street, CN 269
Trenton, NJ 08646-0269

The agency proposal follows:

Summary

This proposed new rule sets forth guidelines for the purchase of goods and services on a tax exempt basis by certain student organizations. The rule makes it clear that student organizations which the school recognizes and sanctions for educational purposes, but which have not qualified for exemption from sales tax on their own account, may be deemed an integral part of the school, and therefore make tax exempt purchases under the following circumstances: first, the event or activity to which the purchase relates must be authorized and supervised by the school; second, payment for the goods or services must be made from a school account; and third, the vendor must be provided with the appropriate documentation, such as, in the case of private schools, a copy of the school's Exempt Organization Permit (ST-5). The rule also specifies certain organizations not considered integral components of the school, so as not to be eligible for exemption under this rule, such as student organizations not sponsored by the school, booster clubs and alumni associations.

Social Impact

This proposed new rule will instruct New Jersey vendors and school groups as to the circumstances of exemption and the required documentation. This should reduce, if not eliminate, errors on the part of both parties with respect to whether tax is due on a sale. In this regard, the rule will also make guidelines available to tax practitioners who can then correctly advise their clients with certainty and on a timely basis.

Economic Impact

The rule should not result in any applicable increase or decrease in sales tax revenue. Many school groups already claim exemption and vendors will sometimes, and mistakenly, grant exemption. On the other hand, school groups which qualify for exemption may pay sales tax that was not required to be paid on a purchase.

Regulatory Flexibility Analysis

The proposed new rule will impose compliance requirements on certain student organizations, which may be considered small businesses within the meaning of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These requirements as to event or activity, sanctioning, form of payment and exemption documentation, however, must be applied uniformly to all taxpayers under the provisions of the New Jersey Sales and Use Tax Act. The law expressly deems all sales of goods and services to be subject to sales tax, unless the vendor has taken a valid exemption certificate or other evidence of exemption acceptable to the Division of Taxation from the purchaser. Thus, any action to exempt taxpayers who may be small businesses would not be in compliance with the Sales and Use Tax Act. In addition, receiving and maintaining exemption documents is in the interest of all taxpayers, including small businesses, since the existence of such documents is necessary for audit purposes. Compliance costs are minimal, related only to form of payment and exemption documentation. No professional services will be needed to comply. The good faith acceptance of an exemption certificate relieves a vendor of liability for the tax with respect to the transaction to which the certificate relates.

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

18:24-9.13 [(Reserved)] **Student organization purchases**

(a) Student organizations within a school exempt from tax under N.J.S.A. 54:32B-9(a) or (b) may be considered integral components of the school and may make tax exempt purchases for educational purposes, including school sponsored fundraising activities and functions, and events such as proms and similar activities, provided:

1. The event or activity is sanctioned and supervised by the board of education, school district, or school administration;

2. Payment in the form of a check or voucher is made from a school, school district, or board of education account, including a student activities account maintained under the auspices of the school and/or the board of education; and

3. Documentation is provided to the vendor to properly evidence the tax exempt purchase. The only acceptable documentation for private schools is a copy of a valid ST-5 Exempt Organization Certificate. New Jersey public schools are New Jersey government entities and as such are not issued exemption certificates or exempt organization numbers. A school contract, letterhead, or purchase order signed by a school official is sufficient to document the exemption.

(b) School affiliated teacher organizations and parent organizations that do not qualify as specifically exempted parent-teacher associations and organizations, student organizations not sponsored by the school, and other school support groups such as booster clubs and class alumni associations are not considered integral components of the school. They are deemed to be separate legal entities and may not use the school's tax exempt documentation to make tax exempt purchases. Such organizations may apply for and receive exempt organization permits, if qualified for exemption under N.J.S.A. 54:32B-9(b)(1) of the Sales and Use Tax Act.

OTHER AGENCIES

(a)

ELECTION LAW ENFORCEMENT COMMISSION

Lobbying Fee Schedule

Proposed Amendment: N.J.A.C. 19:25-20.19

Authorized By: Election Law Enforcement Commission, Frederick M. Herrmann, Ph.D., Executive Director.
Authority: N.J.S.A. 52:13C-23j and 23.2.
Proposal Number: PRN 1994-656.

Submit written comments by January 18, 1995 to:
Gregory E. Nagy, Esq., Legal Director
Election Law Enforcement Commission
CN 185
Trenton, New Jersey 08625-0185

The agency proposal follows:

Summary

The Election Law Enforcement Commission (hereafter, the Commission) proposes at N.J.A.C. 19:25-20.19 to increase the annual registration and filing fee of legislative agents filing notices of representation and quarterly reports from $200.00 to $325.00. Payment of the $325.00 fee covers the registration and all filings of the legislative agent made during a 12-month period commencing on August 1 and ending on July 31.

Social Impact

On January 1, 1992, comprehensive amendments to the Legislative Activities Disclosure Act (hereafter, the Act) became effective, see P.L. 1991, c.243 and c.244, amending N.J.S.A. 52:13C-18 et seq. The amendments specifically authorized the Commission to establish reasonable fees for various lobbying filings, provided that the amount of such fees does not exceed the costs to the Commission of processing and maintaining the reports, and the costs of compiling, summarizing, and publishing information contained in them, see N.J.S.A. 52:13C-23j. The amendments did not contain any appropriation for implementation by the Commission.

The Commission established the current fee of $200.00 per year based on its estimate that the annual cost of processing and maintaining notices and reports, and of compiling, summarizing and publishing information contained in those notices and reports would be approximately $160,000 (see 24 N.J.R. 1245(a), 1246 (April 6, 1992)). These costs included: salaries, equipment, printing, supplies, postage and telephone.

The Commission estimates that in the current fiscal year (July 1, 1994 to June 30, 1995), its costs for the above-described activities will be $200,405. There are currently approximately 600 legislative agents registered with the Commission. Therefore, dividing current anticipated costs by the number of legislative agents, the Commission concludes that its costs per agent are $334.00. For these reasons, the Commission believes the proposed $325.00 annual fee, which is less than the $334.00 per agent annual cost of the program, is reasonable.

The Commission continues to believe that in adopting the amendments to the Act, the Legislature intended that the reasonable costs to the Commission of administering the Act should be borne principally by legislative agents, and by the lobbyists that employ them.

Economic Impact

The proposed amendment will increase the cost of compliance for legislative agents. However, the Commission believes that the increase is necessary and reasonable. Further, the Commission notes that the increase will not affect any person who is receiving less than the minimum compensation amount of $100.00 or less in any three-month period for lobbying services because that person does not meet the statutory definition of "legislative agent" provided in N.J.S.A. 52:13C-20g. Therefore, such a person need not register or file. In the event such a person registers and files on a voluntary basis, the person is specifically exempted from any fees pursuant to N.J.A.C. 19:25-20.8, Voluntary statements. Also, the Commission notes that no annual fee is required if the legislative agent is an organization that is exempt from sales and use taxes pursuant to N.J.S.A. 54:32-9(b), see N.J.A.C. 19:25-20.19(e).

Regulatory Flexibility Analysis

Some legislative agents may be considered small businesses, as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendment imposes no additional reporting or recordkeeping requirements on legislative agents. The amendment increases the annual fee to be paid by legislative agents from $200.00 to $325.00. Because the fee increase is necessary in order to enable the Commission to fulfill its statutory responsibilities concerning legislative agents, and since such costs do not vary significantly based upon the agent's business size, a lesser fee for small businesses is not provided.

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

19:25-20.19 Annual fee

(a) Effective August 1, [1992 and each August 1 thereafter] **1995**, each legislative agent who is an individual and whose activities during any part of a 12-month period commencing on August 1 and ending on the following July 31 are subject to the Act shall pay an annual fee of [$200.00] **$325.00**.

(b) In the event that the legislative agent is a partnership, committee, association, corporation, or other organization or group of persons, the annual fee shall be [$200.00] **$325.00** for each individual from the partnership, committee, association, corporation, or other organization or group of persons, who is required to wear a name tag pursuant to N.J.A.C. 19:25-20.6.

(c)-(e) (No change.)

(b)

CASINO CONTROL COMMISSION

Rules of the Games
Craps
Supplemental Wagers
Proposed Amendment: N.J.A.C. 19:47-1.6

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.
Authority: N.J.S.A. 5:12-5, 63c, 69, 70f, 99b(16) and 100a, (e), (f) and (g).
Proposal Number: PRN 1994-634.

Submit written comments by January 18, 1995 to:
Leonard J. DiGiacomo, Senior Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and Boardwalk
Atlantic City, NJ 08401

The agency proposal follows:

Summary

The Casino Control Act (Act) permits only authorized games to be played in a casino or a casino simulcasting facility in accordance with regulations promulgated by the New Jersey Casino Control Commission (Commission). N.J.S.A. 5:12-100a. At craps, which is one of the authorized games, a casino licensee may offer patrons the opportunity to make a supplemental wager in support of a Pass Bet, Don't Pass Bet, Come Bet and Don't Come Bet (each, an "original wager") that is up to five times the amount of the original wager or calculated to provide a winning patron with winnings of up to five times the amount of the original wager. N.J.A.C. 19:47-1.6(e). Those supplemental wagers are referred to in the industry as "five times odds."

This proposed amendment would allow casino licensees to offer a supplemental wager in craps that is up to 10 times the amount of an original wager, provided the casino licensee does so by giving the requisite notice thereof pursuant to N.J.A.C. 19:47-8.2 and 8.3. Because those two sections specifically require casino licensees to give notice of minimum and maximum wagers, such as those offered as supplemental craps wagers, the separate notice requirements to that effect in N.J.A.C. 19:47-1.6 are being deleted. The industry had expressed a desire to offer this option to patrons. The proposed amendment also will apply the uniform terminology "supplemental wager" in place of "additional wager" in order to reflect the true nature of the bet that is permitted.

Social Impact

The Commission does not anticipate that the proposed amendment will have any overall societal impact. To the extent there is any social impact, it will be felt by casino licensees and their customers. Although

that impact is impossible to predict, the Commission anticipates that the flexibility set forth in the amendment may increase the enjoyment that patrons apparently derive from the gaming experience.

Economic Impact

Under the proposed amendment, no casino licensee is required to offer patrons an opportunity to make a supplemental wager that is greater than the amount of the original wager. The choice to do so remains with the individual licensees, and therefore, any administrative costs, which the Commission anticipates will be nominal. In any event the costs that a casino licensee may incur in complying with the amendment will be directly attributable to the business discretion of the individual licensee rather than the amendment itself.

Should one or more casino licensees exercise the option to offer supplemental wagers in excess of five times the amount of the original wager in the current regulation, it is impossible to predict the economic impact on those licensees, or on those that elect not to offer the supplemental wager. However, any such economic consequences are a result of normal market forces common in the casino industry over which the proposed amendments are likely to have little, if any, control.

Regulatory Flexibility Statement

No regulatory flexibility analysis is required because the proposed amendment will only affect the operation of New Jersey casino licensees, none of which is a "small business" as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16, et seq.

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

19:47-1.6 Supplemental wagers made after come out roll in support of pass, don't pass, come and don't come bets (making and laying odds)

(a) Whenever a player makes a Pass Bet and a total of 4, 5, 6, 8, 9 or 10 is thrown on the come out roll, [he] **the player** shall have the right to make [an additional] **a supplemental** wager in support of the Pass Bet which may be limited by the casino licensee to an amount **that is** equal to the amount of the original Pass Bet. If, in such circumstances, the Pass Bet wins, the original [amount of the] Pass Bet shall be paid at odds of 1 to 1 and the supplemental [amount] **wager** shall be paid at odds of 2 to 1 if the come out point was 4 or 10, 3 to 2 if the come out point was 5 or 9, and 6 to 5 if the come out point was 6 or 8.

(b) Whenever a player makes a Don't Pass Bet and a total of 4, 5, 6, 8, 9 or 10 is thrown on the come out roll, [he] **the player** shall have the right to make [an additional] **a supplemental** wager in support of the Don't Pass Bet which may be limited by the casino licensee to an amount so calculated as to provide winnings not in excess of the amount originally wagered on the Don't Pass Bet. If, in such circumstances, the Don't Pass Bet wins, the original [amount of the] Don't Pass Bet shall be paid at odds of 1 to 1 and the supplemental [amount] **wager** shall be paid at odds of 1 to 2 if the come out point was 4 or 10, 2 to 3 if the come out point was 5 or 9, and 5 to 6 if the come out point was 6 or 8.

(c) Whenever a player makes a Come Bet and a total of 4, 5, 6, 8, 9 or 10 is thrown on the roll immediately following placement of such bet, [he] **the player** shall have the right to make [an additional] **a supplemental** wager in support of the Come Bet which may be limited by the casino licensee to an amount **that is** equal to the amount of the original Come Bet. If, in such circumstances, the Come Bet wins, the original [amount of the] Come Bet shall be paid at odds of 1 to 1 and the supplemental [amount] **wager** shall be paid at odds of 2 to 1 if the come point was 4 or 10, 3 to 2 if the come point was 5 or 9, and 6 to 5 if the come point was 6 or 8.

(d) Whenever a player makes a Don't Come Bet and a total of 4, 5, 6, 8, 9 or 10 is thrown on the roll immediately following placement of such bet, [he] **the player** shall have the right to make [an additional] **a supplemental** wager in support of the Don't Come Bet which may be limited by the casino licensee to an amount so calculated as to provide winnings not in excess of the amount originally wagered on the Don't Come Bet. If, in such circumstances, the Don't Come Bet wins, the original [amount of the] Don't Come Bet shall be paid at odds of 1 to 1 and the supplemental [amount] **wager** shall be paid at odds of 1 to 2 if the come point was a 4 or 10, 2 to 3 if the come point was 5 or 9, and 5 to 6 if the come point was 6 or 8.

(e) A casino licensee may allow [an additional] **a supplemental** wager in support of a Pass or Come Bet in an amount up to [five] **10** times the amount of the original Pass or Come Bet. A casino licensee may allow [an additional] **a supplemental** wager in support of a Don't Pass or Don't Come Bet in an amount so calculated as to provide **a winning player with** winnings not in excess of up to [five] **10** times the amount originally wagered on the Don't Pass or Don't Come Bet. The original Pass, Don't Pass, Come or Don't Come Bet and any [additional] **supplemental** wager allowed pursuant to this subsection shall be paid at the same odds as the original and supplemental wagers are paid under (a) through (d) above. [The amount of the additional wager accepted from the patron may exceed the maximum additional wager otherwise allowed and posted pursuant to (f) below, to the extent that a wager in excess of the maximum is necessary to facilitate the payout permitted herein.]

(f) [Any casino licensee offering additional wagers greater than the additional wagers authorized under (a) through (d) above shall advise patrons of the maximum additional wager being offered by complying with the notice requirements set forth in N.J.A.C. 19:47-8.3.] **Notwithstanding (e) above, a casino licensee may accept a supplemental wager that exceeds an amount that is otherwise authorized by this section or posted as the maximum wager permitted pursuant to N.J.A.C. 19:47-8.2 and 8.3 provided that the excess amount of the supplemental wager is necessary to facilitate the payouts permitted by this section.**

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Prosthetic and Orthotic Services Manual

Proposed Repeal: N.J.A.C. 10:55-1, 2 and 3
Proposed New Rules: N.J.A.C. 10:55-1 and 2

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

Authority: N.J.S.A. 30:4D-6b(6); 30:4D-7, 7a, b and c; 30:4D-12.

Agency Control Number: 94-P-29.

Proposal Number: PRN 1994-655.

A copy of this proposal is available for review at the 21 county welfare boards and the 11 Medicaid District Offices.

Submit comments by January 18, 1995 to:

Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance and Health Services
Mail Code #26
CN 712
Trenton, New Jersey 08625-0712

The agency proposal follows:

Summary

For the purpose of this summary the acronym "P&O" will be interchangeable with the term "prosthetic and orthotic."

N.J.A.C. 10:55 became effective on March 8, 1990, for a period of five years which expires on March 8, 1995. The Division of Medical Assistance and Health Services has made an administrative review and determined that the rules are generally necessary, reasonable and adequate for the purpose for which they were originally intended with the changes proposed herein. The intent of this proposal is to set forth rules (policies and procedures) pertaining to the provision of, and reimbursement for, Medicaid covered prosthetic and orthotic services.

N.J.A.C. 10:55-1 contains the chapter's introduction, definitions, provisions for provider participation, prior authorization process, prescription policies, policy on footwear, and regulations governing reimbursement for prosthetic and orthotic appliances.

N.J.A.C. 10:55-2, entitled "Billing Procedures," provides the information and procedures that providers need to follow in order to secure

payment. Since the last readoption, the Division of Medical Assistance and Health Services has contracted with Unisys as their fiscal agent. Therefore, text in N.J.A.C. 10:55-2 is being deleted and the subchapter is being repealed. Information and procedures for billing can be found in a new Appendix A, entitled Fiscal Agency Billing Supplement.

N.J.A.C. 10:55-3, entitled HCFA Common Procedure Coding System (HCPCS) will, for the first time, appear in its entirety as part of the code. This subchapter has been recodified as N.J.A.C. 10:55-3.

Appendix A

The existing text of N.J.A.C. 10:55-2 is being repealed because of the change in the Division's fiscal agent, which is now Unisys.

There have been no amendments to this chapter since the last readoption.

The following summary highlights the substantive provisions of the respective subchapters, with an emphasis on revisions:

Subchapter 1. General Provisions

N.J.A.C. 10:55-1.1 Introduction

The Division has added text explaining that the chapter addresses the provision of and reimbursement for required services to attain and maintain the highest practicable functional status to meet the needs of the individual.

N.J.A.C. 10:55-1.2 Definitions

The proposed text, previously found in N.J.A.C. 10:55-1.1, has been updated and expanded to provide clarification and new definitions. The current text has four definitions:

"Certification" has been deleted because it is no longer appropriate to the chapter.

"Custom-made." This definition remains basically the same; however references to hearing aid, dentures, artificial eyes were deleted as they are covered in their appropriate subchapter.

"Orthotic appliances" and "Prosthetic appliances" were retained with the addition of clarifying language indicating the types of devices that generally fit these definitions.

The following new definitions can be found at N.J.A.C. 10:55-1.2: "Accreditation", "Facility", "Orthotist", "Pedorthist", "Practitioner", and "Prosthetist".

N.J.A.C. 10:55-1.3 Requirements for approval as a provider of prosthetic and orthotic services

Information in this section is currently at N.J.A.C. 10:55-1.2, entitled "Eligible providers". Language has been added or modified for clarification. The intent of this section is to establish regulations that shall be followed in order to participate as a provider of prosthetic and orthotic services in the New Jersey Medicaid program.

Text has been reorganized for clarity. There is no change in basic policy. A brief description of the clarified text regarding the provider enrollment process follows:

If a provider of prosthetic and orthotic services seeks to become a provider in the New Jersey Medicaid Program, he/she must file an application with the N.J. Medicaid Program. The provider must include a copy of the facility and personnel certification (by the American Board for Certification in Orthotics and Prosthetics). The provider can apply for either orthotics, or prosthetics, or both.

The Division of Medical Assistance and Health Services (the Division) will review the provider's application. If the provider's application is approved, the Division will grant either full approval or conditional approval. The requirements for the appropriate provider states are listed in the text. However, provisional approval can be granted for a period of one year (365 days) if the provider's application (to the American Board for Certification in Orthotics and Prosthetics) is pending.

In the event a certified facility loses its certified prosthetist, orthotist, and/or pedorthist, the provider is required to notify the fiscal agent within five working days of the loss. The Division will grant the provider a 180 day grace period before terminating the provider's participation in Medicaid. However, the provider must use authorized personnel, that is, whose board eligibility is established when fabricating appliances for Medicaid.

N.J.A.C. 10:55-1.4 Requirements for program participation as a prosthetic and orthotic services provider

The proposed text is updated and expanded from that text currently at N.J.A.C. 10:55-1.7 to provide more detail and identify requirements that are based on already existing practices.

This section indicates that an approved Medicaid provider is responsible for issuing an appliance that conforms to the prescribed prescription and description of the appliance. The provider is also responsible for insuring proper fit and for providing maximum efficiency and comfort consistent with the recipient's condition.

The provider must assume liability for defective materials over which the provider has, or should have had, control.

The provider agrees to accept return of an appliance when the prescribing physician has indicated, following an evaluation of the patient, that the appliance needs correction.

The provider also warrants against defective material and workmanship for a period of one year. There are exceptions, including parts worn from natural use, a change in the patient's condition, or misuse by a patient. These requirements are essentially the same as those contained in the existing text of N.J.A.C. 10:55-1.7(b).

The Division's ability to pay providers for appliances is more appropriately described in reimbursement.

N.J.A.C. 10:55-1.5 Prior authorization for prosthetic and orthotic appliances

Information in this section is currently at N.J.A.C. 10:55-1.4 and N.J.A.C. 10:55-1.6.

Specific changes in this section are as follows:

(a) The prior authorization threshold has been increased from $0 to $1,000 for prosthetics.

(b) The prior authorization threshold has been increased from $0 to $500.00 for orthotics (exclusive of foot and ankle orthotics).

(c) Prior authorization requirements for temporary prostheses have been eliminated.

(d) The time frames for notification of the fiscal agent when the facility loses certification have been changed from three days to five working days.

(e) The prior authorization threshold for replacement of parts has been changed from $100.00 to $250.00 (except in emergency situations).

(f) A new prior authorization threshold for labor (separate from repairs), $250.00, has been added.

(g) The requirement for the provider to submit prescription along with the claim form to the fiscal agent has been eliminated, except when the repair/replacement of parts is less than $250.00. Information in this section is currently found in N.J.A.C. 10:55-1.6.

(h) Prior authorization for all orthopedic footwear and foot orthotics must continue to be obtained from the DMAHS Podiatric Consultant, except for all components of orthopedic footwear attached to a bar or brace (including the bar, brace, and/or shoe) which must be obtained from the appropriate Medicaid District Office. Information in this section is currently found in N.J.A.C. 10:55-1.5(c).

(i) The proposed rule codifies the existing requirement that all orthopedic footwear and foot orthotics be prior authorized by the Division's podiatric consultant. However, the process for the provider is basically the same in that they have to obtain prior authorization from the appropriate individual(s) in the Division.

(j) Travel reimbursement requirements have been moved to N.J.A.C. 10:55-1.8, which is entitled Reimbursement for prosthetic and orthotic appliances, as this section is more appropriate.

N.J.A.C. 10:55-1.6 Prescription policies

The proposed text has been moved from N.J.A.C. 10:55-1.3 with a few modifications, as follows:

N.J.A.C. 10:55-1.6(a) expands the policy to include the need for a prescription for repair and/or replacement of parts for custom-made prosthetic and orthotic appliances or orthopedic footwear.

N.J.A.C. 10:55-1.6(b)3, regarding prescription breakdown, remains the same but has been restructured for clarity.

N.J.A.C. 10:55-1.7, Footwear, is currently found at N.J.A.C. 10:55-1.5, entitled "Policy on shoes". Sections (a) and (b) have been copied verbatim, except that a modification has been made, replacing the word "shoes" with "orthopedic footwear" or "footwear".

The current N.J.A.C. 10:55-1.5 has been recodified to the new N.J.A.C. 10:55-1.7, minus subsections (c) through (f). Subsections (e) through (f) provided billing instructions that are no longer used, due to a change in the Division's fiscal agent. Information regarding new billing procedures can be found in Appendix A, Fiscal Agent Billing Supplement.

N.J.A.C. 10:55-1.8, Reimbursement for prosthetic and orthotic appliances, has been recodified from N.J.A.C. 10:55-1.9, entitled "Policies

and Procedures governing reimbursement for prosthetic and orthotic appliances."

The travel reimbursement policy contained in this new rule has been moved from N.J.A.C. 10:55-1.5, and has been changed to only reimburse for travel in excess of five miles one way. If more than one recipient is seen during the visit, travel allowance may only be billed for the initial recipient.

Subchapter 2. HCFA Common Procedure Coding System (HCPCS)

This material was previously referenced, but not reproduced, at N.J.A.C. 10:55-3. With this readoption, the Division has included the full text of the HCPCS codes.

N.J.A.C. 10:55-2.1 Introduction

This section provides an overview of the subchapter.

N.J.A.C. 10:55-2.2 Elements of HCPCS coding system which require attention of the provider

This section provides an overview of the structure of the list of HCPCS procedure codes in N.J.A.C. 10:55-2.3 and 2.4.

N.J.A.C. 10:55-2.3 HCPCS procedure codes and maximum fee allowance schedule for orthotic services

This section provides specific information for each code given, under columns with the titles "HCPCS CODE", "DESCRIPTION", and "MAXIMUM FEE ALLOWANCE" for orthotic services.

N.J.A.C. 10:55-2.4 HCPCS procedure codes and maximum fee allowance schedule for prosthetic services

This section provides specific information for each code given under columns with the titles "HCPCS CODE", "DESCRIPTION", and "MAXIMUM FEE ALLOWANCE" for prosthetic services.

The following are all the changes to N.J.A.C. 10:55-2.1, 2.2, 2.3 and 2.4:

(a) Additional language has been added to clarify that the fee schedule shall be used when the provider of prosthetic and orthotic services is requesting reimbursement from the New Jersey Medicaid program for services rendered to a New Jersey Medicaid recipient.

(b) A reduction in reimbursement is proposed for some services, specifically those services where the Medicaid fee schedule exceeds the Medicare fee schedule.

(c) Fees have now been established for a number of procedure codes which were formerly listed as reimburseable "by report." In those instances, providers were expected to submit documentation and reimbursement was established based on a review of the documentation.

Appendix A—Fiscal Agent Billing Supplement, contains filling directions. N.J.A.C. 10:55-2, which contains billing procedures, is being repealed because of the change in the Division's fiscal agent to Unisys.

Social Impact

The changes will benefit all Medicaid prosthetic and orthotic recipients. Raising of the prior authorization threshold and selective elimination of the prior authorization requirements is likely to facilitate the delivery of services to recipients.

This proposed readoption impacts directly on those prosthetic and orthotic service providers (30) that are participating providers in the New Jersey Medicaid program. The proposed text indicates the services they need to provide, the basis of reimbursement, the method of billing, and the requirements of program participation and provides the basis for continued Medicaid coverage of prosthetic and orthotic services.

The rules are necessary to clearly establish the requirements for P&O "providership" and the services that are rendered to Medicaid recipients.

Economic Impact

Medicaid recipients are not required to contribute to the cost of prosthetic and orthotic services.

The 1994 HCFA Common Procedure Coding System (HCPCS) utilized by the New Jersey Medicaid program includes codes published in Medicare's National Level II codes. The current codes published in the 1994 Medicare National Level II codes reflect a major change in the nomenclature and the amount of Medicare allowable reimbursement for prosthetic and orthotic services from Region A (Northeast) Durable Medical Equipment Regional Carrier (DMERC). This readoption also proposes to adjust Medicaid fees for those services which exceed the Medicare allowable fee. In preparing this readoption, the Division examined the fee structure for prosthetic and orthotic providers and made adjustments which make the fees more consistent with the Medicare allowable fee schedule. In State Fiscal Year 1994, the Medicaid program reimbursed prosthetic and orthotic providers $5,765,676 (Federal and State Shares combined) for services. It is estimated that the reduction in the Medicaid fee schedule for selected services will result in a reduction of less than $100,000.

Regulatory Flexibility Analysis

Some providers may be considered small business under the rules of the Regulatory Flexibility Act, N.J.S.A. 52:14D-16. Therefore a regulatory flexibility analysis is required.

The requirements apply equally to all P&O providers, regardless of size. All providers are already required to maintain sufficient records to indicate the name of the recipient, date of service, nature of service, etc. (N.J.S.A. 30:4D-12). Providers are required by these rules to bill the Medicaid program in the manner prescribed in the Medicaid Fiscal Agent Billing Supplement. Again, the requirements apply equally to all providers.

The Division does not anticipate any capital costs associated with this readoption.

Full text of the proposed repeal may be found at N.J.A.C. 10:55.

Full text of the proposed new rules follows:

CHAPTER 55
PROSTHETIC AND ORTHOTIC SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

10:55-1.1 Introduction

(a) This chapter of the manual N.J.A.C. 10:55 outlines the rules of the New Jersey Medicaid program relevant to the provision of prosthetic and orthotic services to Medicaid recipients. It also lists the specific requirements which must be followed in order to be approved and to participate as a New Jersey Medicaid provider of prosthetic and orthotic services.

(b) The Prosthetic and Orthotic Services Manual N.J.A.C. 10:55 does not include rules for the provision to Medicaid recipients of dentures, artificial eyes, or hearing aids. These services are covered in the New Jersey Medicaid program's Dental Services Manual N.J.A.C. 10:56, Vision Care Services Manual N.J.A.C. 10:62, and the Hearing Aid Services Manual N.J.A.C. 10:64, respectively.

10:55-1.2 Definitions

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

"Accredited" means those facilities that have met the standards of qualification as established by the American Board of Certification in Orthotics and Prosthetics, Incorporated, 1650 King Street, Suite 500, Alexandria, VA 22314-2747.

"Certified" means those individuals that have met the standards of qualification and the requirements as established by the American Board of Certification in Orthotics and Prosthetics, Incorporated (see address above).

"Custom-made" means a device or appliance fabricated (constructed and/or assembled) in an approved facility (see N.J.A.C. 10:55-1.3) and designed to fit and perform a useful function solely for that individual for whom it was ordered.

"Facility" means the work area of operation of the prosthetist, orthotist or pedorthist.

"Orthotic appliances" means a device or brace prescribed by a physician or other practitioner, within the scope of his or her practice as defined by State law, for the purpose of providing support, increased function, and overcoming physical impairment or defects.

1. A brace includes rigid and semi-rigid devices used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

"Orthotist" means one certified by the American Board of Certification in Orthotics and Prosthetics, Incorporated in the profession of measuring, designing, fabricating and fitting of orthotic devices.

"Pedorthist" means one certified by the American Board of Certification in Orthotics and Prosthetics, Incorporated in the

profession of designing, manufacturing, fitting and modification of footwear and related appliances.

"Practitioner" means a physician or other medical care individual licensed or certified under State law to practice his or her profession.

"Prosthetic appliances" means functional replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner within the scope of his or her practice as defined by State law to:

1. Artificially replace a missing portion of the body; or
2. Prevent or correct physical deformity or malfunction; or
3. Support a weak or deformed portion of the body.

"Prosthetist" means one certified by the American Board of Certification in Orthotics and Prosthetics, Incorporated in the profession of making of artificial parts to replace a missing body part or to augment the performance of a natural function externally.

10:55-1.3 Requirements for approval as a provider of prosthetic and orthotic services

(a) In order to be a fully approved New Jersey Medicaid provider of prosthetic and orthotic services, the applicant shall:

1. Submit a completed application (see N.J.A.C. 10:49-3.2) together with a copy of the facility and personnel accredition/certification by the American Board for Certification in Orthotics and Prosthetics. (The applicant may be applying for either orthotics or prosthetics or both) and;

2. Meet the following criteria:

i. Appliances shall be fabricated in the facility and not sent out to another facility;

ii. The facility shall employ personnel (owner and/or employee(s)) certified in the field of speciality of the appliance(s) being produced by that facility.

(1) Exception: If the provider or facility limits the scope of practice to shoe orthotics, custom molded shoes, and shoe modifications, accreditation/certification by the Board for Certification in Pedorthics may be accepted in lieu of accreditation/certification by the American Board for Certification in Orthotics and Prosthetics.

iii. Facilities and their qualified personnel shall maintain current accredition/certification by the American Board for Certification in Orthotics and Prosthetics, Incorporated.

(b) In order to be granted "provisional" approval by the New Jersey Medicaid program, facilities and/or personnel whose application for accredition/certification is pending with the American Board for Certification in Orthotics and Prosthetics, Incorporated, the applicant shall:

1. Submit a letter requesting "provisional" provider status together with a copy of the American Board for Certification in Orthotics and Prosthetics, Incorporated accredition/certification acceptance letter and;

2. Meet the following criteria:

i. Appliances shall be fabricated in the facility and not sent out to another facility;

ii. The facility may be noncertified and may employ certified or noncertified personnel (owner and/or employee(s)).

3. "Provisional" status shall be approved for a period of one year commencing with the date of the letter of acceptance by the American Board for Certification in Orthotics and Prosthetics, Incorporated and shall expire, without further notification, if certification has not been obtained.

(c) If a certified facility loses its certified prosthetist(s), orthotist(s) and/or pedorthist(s), the fiscal agent shall be notified within 5 working days of the loss. A grace period of 180 days from the date of such loss shall be granted for demonstrating recertification before provider eligibility is terminated. In the interval between the loss and recertification of personnel, the minimum requirement for continuing acceptable Medicaid provider eligibility is that fabricated appliances must be fabricated by personnel whose board eligibility is established.

10:55-1.4 Requirements for program participation as prosthetic and orthotic services provider

(a) An approved Medicaid provider of prosthetic and orthotic services, shall be responsible for the following:

1. Assuring that an appliance furnished by the approved facility conforms to the prescriber's prescription and the description of the appliance as set forth in the accepted nomenclature used by the American Board for Certification in Orthotics and Prosthetics, Incorporated; fitting the appliance properly to the extent that the recipient's condition(s) permits; and providing maximum efficiency and comfort consistent with the condition(s) of the recipient for whom the appliance is prescribed;

2. Assuming liability for defective materials over which the provider has (or should have had) control;

3. Agreeing to accept return of an appliance when the prescribing physician, after appropriate evaluation of the appliance(s), determines that the appliance(s) does not conform to the prescription and description of the appliance set forth in the accepted nomenclature by the American Board for Certification in Orthotics and Prosthetics, Incorporated; and/or does not fit properly, and/or is not of acceptable quality, and/or does not provide maximum efficiency and comfort consistent with the condition of the recipient for whom it is prescribed, and refabricating the appliance; and

4. Warrantying against defective material and workmanship (except for parts normally worn from natural use) for a period of one year from date of delivery to and acceptance by the recipient. If it is found that either the material or the workmanship is defective, the provider shall be allowed a reasonable opportunity to make such adjustment and/or corrections or replacement without additional charge to the Medicaid program, or the recipient.

i. The warranty shall not apply to an appliance corrected/altered as a result of a change in the recipient's physical condition (anatomical change).

ii. The warranty shall not apply to a misused appliance or an appliance altered by other than the original provider.

10:55-1.5 Prior authorization for prosthetic and orthotic appliances

(a) This section specifies the services that require prior authorization and the procedures to follow. Prior authorization shall be required for:

1. Any prosthetic appliance (except for preparatory (temporary) upper and lower prostheses) for which the provider's charge is $1,000.00 or more;

2. Any orthotic appliance for which the provider's charge is $500.00 or more; or

3. Replacement of parts of an appliance when the cost exceeds $250, except in an emergency (see (d) below);

i. Prior authorization shall not be required for replacement of parts which involve solely the mechanical aspects of an appliance and for which the charge is $250.00 or less.

4. Labor (hourly rate) charges for repair of items or appliances totalling more than $250.00 shall be prior authorized by the Medicaid District Office (MDO). (See codes L4200 and L7500 (Repair), at N.J.A.C. 10:55-2.)

i. Total labor (hourly rate) charges for repair of items or appliances, not under warranty, are reimbursable for up to $250.00.

5. Any foot and ankle orthotic appliance;

6. Any orthopedic footwear; or

7. Custom molded shoes.

(b) If prior authorization is required, the provider shall not provide those items or services until the authorization is received.

(c) To request prior authorization for prosthetic and orthotic services, the provider shall submit form FD-357 (Request for Prior Authorization for Prosthetic and Orthotic Services, see Appendix A), together with a prescription as specified in N.J.A.C. 10:55-1.6, to the appropriate Medicaid District Office (MDO) (see N.J.A.C. 10:49 Appendix-Form #17 for address) or to the Central Office of Medicaid, Office of Medical Affairs and Provider Relations, Division of Medical Assistance and Health Services, Mail Code #15, CN-712, Trenton, New Jersey, 08625-0712.

1. Prior authorization for all orthopedic footwear and foot orthotics shall be obtained from the Central Office of Medicaid, Office

of Medical Affairs and Provider Relations, except for all components of orthopedic footwear attached to a bar or brace (including the bar, brace, and/or shoe), which must be obtained from the appropriate MDO.

i. When requesting prior authorization for custom molded shoes, the provider shall submit a FD-357 form together with a copy of the prescription and a cost estimate which shall include a detailed cost breakdown of the basic shoe plus any additional charges for materials and/or services.

2. The fiscal agent will inform the provider that the authorization request is approved, denied, or suspended. If approved, the letter to the provider will indicate the authorization number that must be recorded at Item 23B on the 1500 N.J. claim form.

(d) The Medicaid District Office shall grant authorization by telephone when an emergency condition exists, as defined in (d)1, below, and N.J.A.C. 10:49-6.1.

1. When an orthotic or prosthetic appliance or device becomes non-functional due to mechanical failure and must be repaired immediately for the recipient to continue normal functional behavior, the situation shall be considered an emergency. Emergencies include, but are not limited to, mechanical breakdown, fitting problems due to anatomical change, skin breakdown, irritation and/or ulcer, pressure pain, or an ill-fitting socket.

10:55-1.6 Prescription policies

(a) A personally signed and dated order (prescription) by the prescriber shall be required for the following:

1. Prosthetic and orthotic appliances;

2. Repair and replacement of parts for custom-made prosthetic and orthotic appliances; and

3. Orthopedic footwear.

(b) The prescription shall include the following:

1. Recipient's name, age, address, HSP (Medicaid) Case Number and Patient Person Number;

2. Relevant diagnosis supporting need for custom-made prosthetic and orthotic appliances; and

3. A detailed breakdown of the appliance ordered, written according to the accepted New Jersey prosthetic and orthotic nomenclature as set forth in the nomenclature accepted by the American Board for Certification in Orthotics and Prosthetics, Incorporated. A prescription written: "leg brace", "artificial limb", "orthopedic shoes", for example, shall not be acceptable.

10:55-1.7 Policy on footwear

(a) For purposes of the New Jersey Medicaid program, "an orthopedic shoe" means footwear, with or without accompanying appliances, used to prevent or correct gross deformities of the feet, which is properly fitted as to length and width, and consists of the following basic parts:

1. Correct straight last line;
2. Heels with sufficient bearing surface;
3. Toe with ample room for function;
4. Sole of sufficient weight for foot protection;
5. Rigid shank;
6. Properly fitting upper;
7. Smooth and protective lining; and
8. Snug fitting heel counter.

(b) Orthopedic footwear shall be reimbursable under the following conditions:

1. When attached to a brace or bar; and/or

2. When part of the normal (customary, usual) postoperative or postfracture treatment program; and/or

3. When used to correct or adapt to gross foot deformities.

10:55-1.8 Reimbursement for prosthetic and orthotic appliances

(a) This section outlines the Program's policy of reimbursement for prosthetic and orthotic services and specifies the procedure for submitting a claim to request payment.

(b) Providers of prosthetic and orthotic appliances shall be reimbursed on a fee-for-service basis not to exceed the maximum fee schedule allowance in N.J.A.C. 10:55-2. Generally, the reimbursement policy for the purchase or repair of any appliance or footwear is in accordance with the lower of the Medicaid maximum fee allowance or the provider's usual and customary charge. In certain instances, a maximum fee allowance can not easily be established because of the variety of items that can be provided under the same HCPCS code. In those instances, the notation "B.R.", by report, is listed in the fee schedule. In those cases, Medicaid reimbursement will be established by the Division after a review of the additional material submitted by the provider.

1. An additional labor charge shall only be paid for repair-related activities after warranty or prescription change. Such a charge shall not be reimbursed for a new item or appliance.

2. If it is necessary for the provider to visit the recipient at home or another setting to measure, fit or deliver an appliance, the following conditions shall apply:

i. The provider shall be reimbursed for travel time when the distance exceeds five miles one way. If more than one recipient is seen during the visit, travel time allowance shall only be billed for the initial recipient, in accordance with procedure code X3680, Travel time, N.J.A.C. 10:55-2.

ii. A maximum of three "home visits" shall be allowed, unless there is adequate documentation, including a prescription, justifying the need for additional visits.

(b) To request reimbursement for a service provided, the provider shall submit a 1500 N.J. claim form using HCPCS procedure code(s) to identify the item or service provided. Instructions for submitting claims for payment are provided in the Fiscal Agent Billing Supplement following this chapter N.J.A.C. 10:55.

1. HCPCS procedure codes are listed in N.J.A.C. 10:55-2—HCPCS, the HCFA (Health Care Financing Administration's) Common Procedure Coding System).

2. Instructions for the completion of claim forms and other forms are provided in the Fiscal Agent Billing Supplement following N.J.A.C. 10:55-2.

i. Requirements for the timely submission of claims are listed in the Administration Chapter of this manual (N.J.A.C. 10:49-7.2).

3. A provider shall submit a copy of the prescription along with the claim form to the fiscal agent, when the charge for repair and/or replacement of parts is less than $250.00.

(c) The provider shall verify recipient eligibility, in accordance with N.J.A.C. 10:49-2. Payment shall not be made for services provided to an ineligible individual, even if the service was prior authorized, except under the following circumstances:

1. If fabrication of an appliance (including repair or replacement of parts on existing appliance) has commenced following authorization but has not been completed during the recipient's period of eligibility, reimbursement to the provider shall be allowed.

2. In circumstances involving the recipient over which no one may have control, such as moving out-of-state, or in case of death of the recipient, reimbursement will be made in an amount consistent with the stage of completion of the appliance consistent with the Program's Maximum Fee Allowance schedule.

i. The provider shall use the date fabrication of the appliance was begun as the date of service when the above situation(s) occur(s).

SUBCHAPTER 2. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:55-2.1 Introduction

(a) The New Jersey Medicaid program has adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS procedure codes listed in this subchapter shall be used when filing a claim for prosthetic and/or orthotic services.

1. The responsibility of the prosthetic and orthotic services provider when rendering services and requesting reimbursement is listed in N.J.A.C. 10:55-1 of the Prosthetic and Orthotic Services Manual.

10:55-2.2 Elements of HCPCS coding system

(a) The list of HCPCS procedure codes in N.J.A.C. 10:55-2.3 and N.J.A.C. 10:55-2.4 is arranged in tabular form with specific information for each code given under columns with the titles "HCPCS CODE," "DESCRIPTION," and "MAXIMUM FEE ALLOWANCE."

(b) The column titled "MAXIMUM FEE ALLOWANCE" indicates the maximum amount of reimbursement or the following symbol:

1. Where "B.R." (By Report) is listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. In such instances, the provider shall attach a copy of the report to the claim form.

(c) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of alphabetic and/or numeric characters at the end of the HCPCS procedure code. The New Jersey Medicaid program's recognized modifier codes for prosthetic and orthotic services are as follows:

1. "RP" (Repair and/or Replacement) is used to indicate repair and/or replacement of prosthetic and orthotic devices. The claim shows the HCPCS procedure code for the repairs and/or parts, followed by the "RP" modifier and the charge for the repairs and/or parts.

2. "XE" (Non-Medicare-covered Service) is used to indicate that a service provided to a Medicare/Medicaid recipient is not reimbursable by Medicare.

10:55-2.3 HCPCS Procedure Codes and Maximum Fee Allowance Schedule for Orthotic Services

HCPCS Code	Description	Maximum Fee Allowance
	(a) ORTHOTIC DEVICES (L0100-L0999)	
	SPINAL: CERVICAL	
L0100	Cervical, craniostenosis, helmet molded to patient model	300.00
L0110	Cervical, craniostenosis, helmet nonmolded	72.00
L0120	Cervical, flexible, nonadjustable (foam collar)	13.04
L0130	Cervical, flexible, thermoplastic collar, molded to patient	54.40
L0140	Cervical, semi-rigid, adjustable (plastic collar)	24.40
L0150	Cervical, semi-rigid, adjustable molded chin up (plastic collar with mandibular/occipital piece)	75.20
L0160	Cervical, semi-rigid, wire frame occipital/mandibular support	100.00
L0170	Cervical collar, molded to patient model	300.00
L0172	Cervical collar, semi-rigid, thermoplastic foam, two piece	68.34
L0174	Cervical collar, semi-rigid, thermoplastic foam, two piece with thoracic extension	113.90
	MULTIPLE POST COLLAR	
L0180	Cervical, multiple post collar occipital/mandibular supports, adjustable	163.80
L0190	Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (Somi, Guilford, Taylor types)	240.00
L0200	Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension	175.00
	SPINAL: THORACIC	
L0210	Thoracic rib belt, custom fitted	13.20
L0220	Thoracic rib belt, custom fabricated	24.40
	SPINAL: THORACIC—LUMBAR—SACRAL ORTHOSIS (TLSO)—FLEXIBLE	
L0300	Thoracic-lumbar-sacral-orthoses (TLSO), flexible (dorso-lumbar surgical support) custom fitted	101.68
L0310	TLSO, flexible, (dorso-lumbar surgical support), custom fabricated	214.80
L0315	TLSO, flexible dorso-lumbar surgical support, elastic type, with rigid posterior panel	120.00
L0317	TLSO, flexible dorso-lumbar surgical support, hyperextension, elastic type, with rigid posterior panel	140.00
	ANTERIOR—POSTERIOR CONTROL	
L0320	TLSO, anterior-posterior control (Taylor type), with apron front	271.60
L0330	TLSO, anterior-posterior-lateral control (Knight-Taylor type), with apron front	304.10
	ANTERIOR—POSTERIOR—LATERAL—ROTARY CONTROL	
L0340	TLSO, anterior-posterior-lateral-rotary control (Arnold, Magnuson, Steindler types), with apron front	428.57
L0350	TLSO, anterior-posterior-lateral-rotary control, flexion compression jacket, custom fitted	621.48
L0360	TLSO, anterior-posterior-lateral-rotary control, flexion compression jacket molded to patient model	800.00
L0370	TLSO, anterior-posterior-lateral-rotary control, hyperextension (Jewett, Lennox, Baker, Cash types)	246.40
L0380	TLSO, anterior-posterior-lateral-rotary control, with extensions	460.00
L0390	TLSO, anterior-posterior-lateral control, molded to patient model	840.00
L0400	TLSO, anterior-posterior-lateral control, molded to patient model, with interface material	952.56
L0410	TLSO, anterior-posterior-lateral control, two-piece construction, molded to patient model	917.48
L0420	TLSO, anterior-posterior-lateral control, two-piece construction, molded to patient model, with interface material	982.15
L0430	TLSO, anterior-posterior-lateral control, with interface material, custom fitted	731.36
L0440	TLSO, anterior-posterior-lateral control, with overlapping front section, spring steel front, custom fitted	651.20
	SPINAL: LUMBAR—SACRAL—ORTHOSIS (LSO)—FLEXIBLE	
L0500	Lumbar-sacral-orthoses (LSO), flexible, (lumbo-sacral surgical supports), custom fitted	77.28
L0510	LSO, flexible (lumbo-sacral surgical support), custom fabricated	113.52
L0515	LSO, flexible (lumbo-sacral surgical support), elastic type, with rigid posterior panel	69.16
	ANTERIOR—POSTERIOR—LATERAL CONTROL	
L0520	LSO, anterior-posterior lateral control (Knight, Wilcox types), with apron front	252.00
	ANTERIOR—POSTERIOR CONTROL	
L0530	LSO, anterior-posterior control (Macausland type), with apron front	192.00
	LUMBAR FLEXION	
L0540	LSO, lumbar flexion (Williams flexion type)	320.00
L0550	LSO, anterior-posterior-lateral control, molded to patient model	760.00
L0560	LSO, anterior-posterior-lateral control, molded to patient model, with interface material	880.00
L0565	LSO, anterior-posterior-lateral, custom fitted	427.14
	SPINAL: SACROILIAC/FLEXIBLE	
L0600	Sacroiliac, flexible (sacroiliac surgical support), custom fitted	40.72
L0610	Sacroiliac, flexible (sacroiliac surgical support), custom fabricated	89.28

	SEMI-RIGID	
L0620	Sacroiliac, semi-rigid (Goldthwaite, Osgood types), with apron front	192.00
	SPINAL: CERVICAL—THORACIC—LUMBAR—SACRAL ORTHOSIS (CTLSO)—HALO/ANTERIOR, POSTERIOR—LATERAL CONTROL	
L0700	Cervical-thoracic-lumbarsacral-orthoses (CTLSO), anterior-posterior-lateral-control, molded to patient model (Minerva type)	1,160.00
L0710	CTLSO, anterior-posterior-lateral-control, molded to patient model, with interface material (Minerva type)	1,280.00
	HALO PROCEDURE	
L0810	Halo procedure, cervical halo incorporated into jacket vest	1,677.11
L0820	Halo procedure, cervical halo incorporated into plaster body jacket	1,200.00
L0830	Halo procedure, cervical halo incorporated into Milwaukee type orthosis	2,053.61
L0860	Addition to halo procedure, magnetic resonance image compatible system	500.00
	SPINAL: TORSO SUPPORTS—PTOSIS AND POSTSURGICAL SUPPORTS	
L0900	Torso support, ptosis support, custom fitted	102.11
L0910	Torso support, ptosis support, custom fabricated	220.33
	PENDULOUS ABDOMEN SUPPORTS	
L0920	Torso support, pendulous abdomen support, custom fitted	118.36
L0930	Torso support, pendulous abdomen support, custom fabricated	250.68
	POSTSURGICAL SUPPORTS	
L0940	Torso support, postsurgical support, custom fitted	110.18
L0950	Torso support, postsurgical support, custom fabricated	240.00
L0960	Torso support, postsurgical support, pads for postsurgical support	48.71
X4070	Apron front replacement	65.12
	ADDITIONS TO SPINAL ORTHOSES	
L0970	TLSO, corset front	33.60
L0972	LSO, corset front	69.20
L0974	TLSO, full corset	88.20
L0976	LSO, full corset	103.88
L0978	Axillary crutch extension	35.00
L0980	Peroneal straps, pair	11.33
L0982	Stocking supporter grips, set of four (4)	9.60
L0984	Protective body sock, each	34.12

(b) ORTHOTIC DEVICES—SCOLIOSIS PROCEDURES (L1000—L1499)

The orthotic care of scoliosis differs from other care in that the treatment is more dynamic in nature and uses ongoing continual modification of the orthosis to the patient's changing condition. This coding structure uses the proper names or eponyms of the procedures because they have historic and universal acceptance in the profession. It should be recognized that variations to the basic procedures described by the founders/developers are accepted in various medical and orthotic practices throughout the country. All procedures include model of patient when indicated.

	SCOLIOSIS: CERVICAL—THORACIC—LUMBAR—SACRAL ORTHOSIS (CTLSO) (MILWAUKEE)	
L1000	Cervical-thoracic-lumbar-sacral orthosis (CTLSO), inclusive of furnishing initial orthoses including model	1,134.00
L1010	Additions to (CTLSO) or scoliosis orthosis, axilla sling	44.88
L1020	Addition to CTLSO or scoliosis orthosis, kyphosis pad	25.00
L1025	Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating	77.29
L1030	Addition to CTLSO or scoliosis orthosis, lumbar bolster pad	40.83
L1040	Addition to CTLSO or scoliosis orthosis, lumbar or lumbar rib pad	39.00
L1050	Addition to CTLSO or scoliosis orthosis, sternal pad	39.00
L1060	Addition to CTLSO or scoliosis orthosis, thoracic pad	39.00
L1070	Addition to CTLSO or scoliosis orthosis, trapezius sling	51.00
L1080	Addition to CTLSO or scoliosis orthosis, outrigger	35.42
L1085	Addition to CTLSO or scoliosis orthosis, outrigger bilateral with vertical extensions	108.45
L1090	Addition to CTLSO or scoliosis orthosis, lumbar sling	51.00
L1100	Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather	66.00
L1110	Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather, molded to patient model	90.00
L1120	Addition to CTLSO or scoliosis orthosis, cover for upright, each	26.05
	SCOLIOSIS: THORACIC—LUMBAR—SACRAL ORTHOSIS (TLSO) (LOW PROFILE)	
L1200	Thoracic-lumbar-sacral-orthosis (TLSO), inclusive of furnishing initial orthosis only	1,037.53
L1210	Additions to TLSO, (low profile), lateral thoracic extension	175.00
L1220	Additions to TLSO, (low profile), anterior thoracic extension	175.00
L1230	Additions to TLSO, (low profile), Milwaukee type superstructure	340.00
L1240	Additions to TLSO, (low profile), lumbar derotation pad	44.75
L1250	Addition to TLSO, (low profile), anterior asis pad	44.75
L1260	Addition to TLSO, (low profile), anterior thoracic derotation pad	44.75
L1270	Addition to TLSO, (low profile), abdominal pad	44.75
L1280	Addition to TLSO, (low profile), rib gusset (elastic), each	61.02
L1290	Addition to TLSO, (low profile), lateral trochanteric pad	40.68
	OTHER SCOLIOSIS PROCEDURES	
L1300	Other scoliosis procedure, body jacket molded to patient model	1,200.00
L1310	Other scoliosis procedure, post-operative body jacket	1,200.00
L1499	Unlisted procedure for spinal orthosis	B.R.

THORACIC—HIP—KNEE—ANKLE ORTHOSIS (THKAO)

L1500	Thoracic-hip-knee-ankle orthoses (THKAO), mobility frame (Newington, Parapodium types)	1,243.33
L1510	THKAO, standing frame	877.67
L1520	THKAO, swivel walker	1,487.44

(c) ORTHOTIC DEVICES—LOWER LIMB (L1600—L2699)

The procedures in L1600—L2999 are considered as "base" or "basic procedures" and may be modified by listing procedures from the "additions" sections and adding them to the base procedures.

LOWER LIMB: HIP ORTHOSIS (HO)—FLEXIBLE

L1600	Hip ortoses (HO), abduction control of hip joints, flexible, Frejka type with cover	40.32
L1610	HO, abduction control of hip joints, flexible, (Frejka cover only)	25.00
L1620	HO, abduction control of hip joints, flexible, (Pavlik harness)	75.00
L1630	HO, abduction control of hip joints, semi-flexible (Von Rosen type)	111.31
L1640	HO, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs	250.00
L1650	HO, abduction control of hip joints, static, adjustable, custom fitted (Ilfled type)	150.00
L1660	HO, abduction control of hip joints, static, plastic, custom fitted	109.07
L1680	HO, abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type)	802.72
L1685	HO, abduction control of hip joints, postoperative hip adduction type, custom fabricated	610.20
L1686	HO, abduction control of hip joint, postoperative hip abduction type, custom fitted	600.00

LOWER LIMB—LEGG PERTHES

L1700	Legg Perthes orthosis, (Toronto type)	996.07
L1710	Legg Perthes orthosis, (Newington type)	1,159.26
L1720	Legg Perthes orthosis, trilateral, (Tachdijan type)	852.85
L1730	Legg Perthes orthosis, (Scottish Rite type)	739.21
L1750	Legg Perthes orthosis, Legg Perthes sling (Sam Brown type)	80.00
L1755	Legg Perthes orthosis, (Patten Bottom type)	854.40

LOWER LIMB—KNEE ORTHOSIS (KO)

L1800	Knee orthosis (KO), elastic with stays	32.56
L1810	KO, elastic with joints	61.04
L1815	KO, elastic with condylar pads	63.19
L1820	KO, elastic with condyle pads and joints	72.40
L1825	KO, elastic knee cap	28.00
L1830	KO, immobilizer; canvas longitudinal	52.88
L1832	KO, adjustable knee joints, positional orthosis, rigid support, custom fitted	320.00
L1834	KO, without knee joint, rigid, molded to patient model	388.00
L1840	KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated to patient model	520.00
L1844	KO, single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, molded to patient model	852.38
L1845	KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fitted	468.00
L1846	KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, molded to patient model	528.80
L1850	KO, Swedish type	148.00
L1855	KO, molded plastic, thigh and calf, sections, with double upright knee joints, molded to patient model	610.20
L1858	KO, molded plastic, polycentric knee joints, pneumatic knee pads (CTI)	610.20
L1860	KO, modification of supracondylar prosthetic socket, molded to patient model (SK)	555.68
L1870	KO, double upright, thigh and calf lacers, molded to patient model with knee joints	488.16
L1880	KO, double upright, nonmolded thigh and calf cuffs/lacers with knee joints	366.16
L1899	Unlisted procedure for lower limb knee	B.R.

LOWER LIMB: ANKLE—FOOT ORTHOSIS (AFO)

L1900	Ankle-foot orthoses (AFO), spring wire, dorsiflexion assist calf band	158.64
L1902	AFO, ankle gauntlet, custom fitted	48.81
L1904	AFO, molded ankle gauntlet, molded to patient model	284.76
L1906	AFO, multiligamentus ankle support	75.00
L1910	AFO, posterior, single bar, clasp attachment to shoe counter	192.99
L1920	AFO, single upright with static or adjustable stop (Phelps or Perlstein type)	200.00
L1930	AFO, custom fitted, plastic	156.80
L1940	AFO, molded to patient model, plastic	387.94
L1945	AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction)	540.00
L1950	AFO, spiral, molded to patient model (Irm type), plastic	593.22
L1960	AFO, posterior solid ankle, molded to patient model, plastic	421.60
L1970	AFO, plastic molded to patient model, with ankle joint	513.35
L1980	AFO, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar "BK" orthosis)	229.60
L1990	AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar "BK" orthosis)	287.20
X4004	Carbon composites at ankle of MAFO, plastic only, each	35.00
X4005	Tone reducing orthoses knee high, custom molded, supply by orthotist, each	1,121.00
X4006	Tone reducing orthoses ankle high, custom molded, supply by orthotist, each	350.00
X4007	Swedo ankle orthoses, each	90.00
X4450	AFO, posterior leaf spring molded to patient model (Tirr, Rancho) includes casting	386.40

LOWER LIMB: HIP-KNEE-ANKLE-FOOT ORTHOSIS (KAFO)—OR ANY COMBINATION

L2000, L2020, and L2036 are base procedures which may be used with any knee joint; L2010 and L2030 shall only be used with no knee joint.

L2000	Knee-ankle-foot-orthoses (KAFO), single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis)	760.00

L2010	KAFO, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar "AK" orthosis), without knee joint	568.68
L2020	KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar "AK" orthosis)	786.13
L2030	KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar "AK" orthosis), without knee joint	571.20
L2036	KAFO, full plastic, double upright, free knee, molded to patient model	1,000.00
L2037	KAFO, full plastic, single upright, free knee, molded to patient model	900.00
L2038	KAFO, full plastic, without knee joint, multiaxis molded to patient model (lively orthosis or equal)	900.00
	TORSION CONTROL: HIP—KNEE—ANKLE—FOOT ORTHOSIS (HKAFO)	
L2040	Hip-knee-ankle-foot orthosis (HKAFO), torsion control, bilateral rotation straps, pelvic band/belt	131.05
L2050	HKAFO, torsion control, bilateral torsion cables, hip joint, pelvic band/belt	223.44
L2060	HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/belt	250.00
L2070	HKAFO, torsion control, unilateral rotation straps, pelvic band/belt	90.76
L2080	HKAFO, torsion control, unilateral, torsion cable, hip joint, pelvic band/belt	200.00
L2090	HKAFO, torsion control unilateral torsion cable, ball bearing hip joint, pelvic band/belt	200.00
	FRACTURE ORTHOSES: ANKLE—FOOT ORTHOSIS (AFO) AND KNEE—ANKLE—FOOT ORTHOSIS (KAFO)	
L2102	Ankle-foot-orthosis (AFO), fracture orthosis, tibial fracture cast orthosis, plaster type casting material molded to patient	162.40
L2104	AFO, fracture orthosis, tibial fracture cast orthosis, synthetic type casting material, molded to patient	203.20
L2106	AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, molded to patient	284.76
L2108	AFO, fracture orthosis, tibial fracture cast orthosis, molded to patient model	569.60
L2112	AFO, fracture orthosis, tibial fracture orthosis, soft custom fitted	244.08
L2114	AFO, fracture orthosis, tibial fracture orthosis, semi-rigid custom fitted	321.37
L2116	AFO, fracture orthosis, tibial fracture orthosis, rigid custom fitted	366.40
L2122	Knee-ankle-foot-orthosis (KAFO), fracture orthosis, femoral fracture cast orthosis, plaster type casting material, molded to patient	508.50
L2124	KAFO, fracture orthosis, femoral fracture cast orthosis, synthetic type casting material, molded to patient	569.60
L2126	KAFO, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, molded to patient	651.20
L2128	KAFO, fracture orthosis, femoral fracture cast orthosis, molded to patient model	895.20
L2132	KAFO, fracture orthosis, femoral fracture cast orthosis, soft custom fitted	488.16
L2134	KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid custom fitted	528.81
L2136	KAFO, fracture orthosis, femoral fracture cast orthosis, rigid custom fitted	630.40
	ADDITIONS TO FRACTURE ORTHOSIS	
L2180	Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints	53.69
L2182	Addition to lower extremity fracture orthosis, drop lock knee joint	48.80
L2184	Addition to lower extremity fracture orthosis, limited motion knee joint	69.16
L2186	Addition to lower extremity fracture orthosis, adjustable motion knee joint, lerman type	101.70
L2188	Addition to lower extremity fracture orthosis, quadrilateral brim	203.40
L2190	Addition to lower extremity fracture orthosis, waist belt	48.81
L2192	Addition to lower extremity fracture orthosis, hip joint pelvic band, thigh flange, and pelvic belt	203.40
X4008	Graphite bands, each	100.00
	ADDITIONS TO LOWER EXTREMITY ORTHOSIS; SHOE—ANKLE—SHIN—KNEE	
L2200	Addition to lower extremity, limited ankle motion, each joint	30.80
L2210	Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint	48.00
L2220	Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint	59.65
L2230	Addition to lower extremity, split flat caliper stirrups and plate attachment	49.95
L2240	Addition to lower extremity, round caliper and plate attachment	54.10
L2250	Addition to lower extremity, foot plate, molded to patient model, stirrup attachment	234.08
L2260	Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)	169.83
L2265	Addition to lower extremity, long tongue stirrup	32.00
L2270	Addition to lower extremity, varus/valgus correction ("T") strap, padded/lined or malleolus pad	35.03
L2275	Addition to lower extremity, varus/vulgus corrections, plastic modification, padded/lined	65.71
L2280	Addition to lower extremity, molded inner boot	105.76
L2300	Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable	175.00
L2310	Addition to lower extremity, abduction bar, straight	80.01
L2320	Addition to lower extremity, nonmolded lacer	96.00
L2330	Addition to lower extremity, lacer molded to patient model	190.00
L2335	Addition to lower extremity, anterior swing band	122.04
L2340	Addition to lower extremity, pretibial shell, molded to patient model	284.80
L2350	Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model (used for "PTB" "AFO" orthoses)	447.52
L2360	Addition to lower extremity, extended steel shank	41.16
L2370	Addition to lower extremity, patten bottom	164.00
L2375	Addition to lower extremity, torsion control, ankle joint and half solid stirrup	75.80
L2380	Addition to lower extremity, torsion control, straight knee joint, each joint	32.00
L2385	Addition to lower extremity, straight knee joint, heavy duty, each joint	52.88
L2390	Addition to lower extremity, offset knee joint, each joint	52.88

L2395	Addition to lower extremity, offset knee joint, heavy duty, each joint	73.60
L2397	Addition to lower extremity orthosis, suspension sleeve	61.53
	ADDITIONS TO STRAIGHT KNEE OR OFFSET KNEE JOINTS	
L2405	Addition to knee joint, drop lock, each joint	24.80
L2415	Addition to knee joint, cam lock (Swiss, French Bail types), each joint	101.60
L2425	Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint	142.00
L2435	Addition to knee joint, polycentric joint, each joint	97.63
L2492	Addition to knee joint, lift loop for drop lock ring	68.80
X4350	Knee pad, standard cap, each	45.00
X4355	Knee pad, pull cap, each	65.00
	ADDITIONS—THIGH/WEIGHT BEARING—GLUTEAL/ISCHIAL WEIGHT BEARING	
L2500	Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring	117.60
L2510	Addition to lower extremity, thigh/weight bearing, quadrilateral brim, molded to patient model	508.81
L2520	Addition to lower extremity, thigh/weight bearing, quadrilateral brim, custom fitted	336.00
L2525	Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim molded to patient model	660.00
L2526	Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim, custom fitted	380.00
L2530	Addition to lower extremity, thigh/weight bearing, lacer, nonmolded	146.48
L2540	Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model	196.00
L2550	Addition to lower extremity, thigh/weight bearing, high roll cuff	61.04
	ADDITIONS: PELVIC AND THORACIC CONTROL	
L2570	Addition to lower extremity, pelvic control, hip joint, clevis type two position joint, each	280.00
L2580	Addition to lower extremity, pelvic control, pelvic sling	240.00
L2600	Addition to lower extremity, pelvic control, hip joint, clevis type, or thrust bearing, free, each	108.00
L2610	Addition to lower extremity, pelvic control, hip joint, clevis or thrust bearing, lock, each	132.00
L2620	Addition to lower extremity, pelvic control, hip joint, heavy-duty, each	160.00
L2622	Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each	170.85
L2624	Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each	102.40
L2627	Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables	840.00
L2628	Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables	840.00
L2630	Addition to lower extremity, pelvic control, band and belt, unilateral	166.88
L2640	Addition to lower extremity, pelvic control, band and belt, bilateral	201.60
L2650	Addition to lower extremity, pelvic and thoracic control, gluteal pad, each	86.80
L2660	Addition to lower extremity, thoracic control, thoracic band	18.00
L2670	Addition to lower extremity, thoracic control, paraspinal uprights	32.00
L2680	Addition to lower extremity, thoracic control, lateral support uprights	32.00
	(d) ADDITIONS—GENERAL (L2750-L2999)	
L2750	Addition to lower extremity orthosis, plating chrome or nickel, per bar	52.00
L2760	Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth)	32.00
L2770	Addition to lower extremity orthosis, any material, per bar or joint	45.67
L2780	Addition to lower extremity orthosis, noncorrosive finish, per bar	40.00
L2785	Addition to lower extremity orthosis, drop lock retainer, each	16.27
L2795	Addition to lower extremity orthosis, knee control, full kneecap	62.21
L2800	Addition to lower extremity orthosis, knee control, kneecap, medical or lateral pull	64.80
L2810	Addition to lower extremity orthosis, knee control, condylar pad	54.57
L2820	Addition to lower extremity orthosis, soft interface for molded plastic, below knee section	40.68
L2830	Addition to lower extremity orthosis, soft interface for molded plastic, above knee section	40.68
L2840	Addition to lower extremity orthosis, tibial length sock, fracture or equal, each	28.00
L2850	Addition to lower extremity orthosis, femoral length sock, fracture or equal, each	33.60
L2999	Unlisted procedures for lower extremity orthoses	B.R.
X3610	"D" rings	12.24
X3620	Bullet (spring loaded) retentions	23.60
X4003	"T" strap medial or lateral with velcro foam padded lined with horse hide	75.00
	(e) ORTHOPEDIC SHOES (L3000-L3649)	
	INSERTS	
L3000	Foot insert, removable, molded to patient model, "UCB" type, Berkeley shell, each	140.00
L3001	Foot insert, removable, molded to patient model, Spenco, each	76.00
L3002	Foot insert, removable, molded to patient model, Plastazote or equal, each	76.00
L3003	Foot insert, removable, molded to patient model, silicone gel, each	76.00
L3010	Foot insert, removable, molded to patient model, longitudinal arch support, each	76.00
L3020	Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each	88.00
L3030	Foot insert, removable, formed to patient foot, each	48.00
X4290	Filler for amputee toes	16.00
	ARCH SUPPORTS, REMOVABLE, PREMOLDED	
X4800	Arch support, foot plates: (plaster cast taken by vendor) leather—whitman ordinary	50.00
X4801	Arch support, foot plate: (plaster cast taken by vendor) leather—mayer	45.00
X4802	Arch support, foot plate: (plaster cast taken by vendor) leather—schaffer	45.00
X4803	Arch support, foot plate: (plaster cast taken by vendor) leather—schaffer with metatarsal pad	75.00
X4804	Arch support, foot plate: (plaster cast taken by vendor) leather—whitman combination	75.00

X4805	Arch support, foot plate: (plaster cast taken by vendor) leather—rohadur plastic	75.00
X4810	Velcro straps, attached to a pair of shoes, per pair	14.00
L3040	Foot, arch support, removable, premolded, longitudinal, each	29.60
L3050	Foot, arch support, removable, premolded, metatarsal, each	32.00
L3060	Foot, arch support, removable, premolded, longitudinal/metatarsal, each	48.00
	ARCH SUPPORT, NON-REMOVABLE, ATTACHED TO SHOE	
L3070	Foot, arch support, nonremovable, attached to shoe, longitudinal, each	16.00
L3080	Foot, arch support, nonremovable, attached to shoe, metatarsal, each	20.00
L3090	Foot, arch support, nonremovable, attached to shoe longitudinal/metatarsal, each	24.00
L3100	Hallus-Valgus night dynamic splint	20.00
	ABDUCTION AND ROTATION BARS	
L3140	Foot, rotation positioning device, including shoe(s)	56.00
L3150	Foot, rotation positioning device, without shoe(s)	60.00
L3170	Foot, plastic heel stabilizer	112.00
	SPACE SHOES	
X4850	Space shoe rubber raise for shoe: ¼" raise	8.00
X4851	Space shoe rubber raise for shoe: ½" raise	9.00
X4852	Space shoe rubber raise for shoe: ¾" raise	13.00
X4853	Space shoe rubber raise for shoe: 1" raise	20.00
X4854	Space shoe rubber raise for shoe: Each addition ½" raise	8.00
	CASTING	
X4890	Foot	50.00
X4891	Foot, ankle	65.00
X4892	Foot, ankle, shin	70.00
X4893	KAFO castings	125.00
	ORTHOPEDIC FOOTWEAR	
L3201	Orthopedic shoe, oxford with supinator or pronator, infant	48.00
L3202	Orthopedic shoe, oxford with supinator or pronator, child	48.00
L3203	Orthopedic shoe, oxford with supinator or pronator, junior	48.00
L3204	Orthopedic shoe, hightop with supinator or pronator, infant	48.00
L3206	Orthopedic shoe, hightop with supinator or pronator, child	48.00
L3207	Orthopedic shoe, hightop with supinator or pronator, junior	48.00
L3208	Surgical boot, each infant	24.00
L3209	Surgical boot, each child	24.00
L3211	Surgical boot, each junior	24.00
L3212	Benesch boot, pair, infant	48.00
L3213	Benesch boot, pair, child	48.00
L3214	Benesch boot, pair, junior	48.00
L3215	Orthopedic footwear, woman's shoes, oxford	76.00
L3216	Orthopedic footwear, woman's shoes, depth inlay	100.00
L3217	Orthopedic footwear, woman's shoes, hightop, depth inlay	116.00
L3218	Orthopedic footwear, woman's surgical boot, each	64.00
L3219	Orthopedic footwear, man's shoes, oxford	76.00
L3221	Orthopedic footwear, man's shoes, depth inlay	100.00
L3222	Orthopedic footwear, man's shoes, hightop, depth inlay	116.00
L3223	Orthopedic footwear, man's surgical boot, each	64.00
L3230	Orthopedic footwear, custom shoes, depth inlay	380.00
L3250	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each	250.00
L3251	Foot, shoe molded to patient model, silicone shoe, each	280.00
L3252	Foot, shoe molded to patient model, Plastazote (or similar), custom fabricated, each	256.00
L3253	Foot, molded shoe Plastazote (or similar), custom fitted, each	112.00
L3254	Nonstandard size or width	20.00
L3255	Nonstandard size or length	20.00
L3257	Orthopedic footwear, additional charge for split size	50.00
L3260	Ambulatory surgical boot, each	88.00
L3265	Plastazote sandal, each	56.00
	SHOE MODIFICATION—LIFTS	
L3300	Lift, elevation, heel, tapered to metatarsals, per inch	64.00
L3310	Lift, elevation, heel and sole, neoprene, per inch	64.00
L3320	Lift, elevation, heel and sole, cork, per inch	100.00
L3330	Lift, elevation, metal extension (skate)	316.00
L3332	Lift, elevation, inside shoe, tapered, up to one-half inch	44.00
L3334	Lift, elevation, heel, per inch	36.00
X4894	Orthopedic shoe, articulared (Bebax type)	72.00
	WEDGES	
L3340	Heel wedge, Sach	10.40
L3350	Heel wedge	12.00
L3360	Sole wedge, outside sole	12.00
L3370	Sole wedge, between sole	14.40
L3380	Clubfoot wedge	12.00
L3390	Outflare wedge	16.00
L3400	Metatarsal bar wedge, rocker	16.00
L3410	Metatarsal bar wedge, between sole	16.00
L3420	Full sole and heel wedge, between sole	24.00
L3430	Heel, counter, plastic reinforced	24.00
L3440	Heel, counter, leather reinforced	24.00
L3450	Heel, Sach cushion type	64.00
L3455	Heel, new leather, standard	8.00
L3460	Heel, new rubber, standard	8.00
L3465	Heel, Thomas with wedge	20.00
L3470	Heel, Thomas extended to ball	24.00
L3480	Heel, pad and depression for spur	16.00
L3485	Heel, pad, removable for spur	32.00
	MISCELLANEOUS SHOE ADDITIONS	
L3500	Miscellaneous shoe addition, insole, leather	4.00
L3510	Miscellaneous shoe addition, insole, rubber	8.00
L3520	Miscellaneous shoe additions, insole, felt covered with leather	8.00
L3530	Miscellaneous shoe addition, sole, half	12.00
L3540	Miscellaneous shoe addition, sole, full	36.00
L3550	Miscellaneous shoe addition, toe tap, standard	4.00
L3560	Miscellaneous shoe addition, toe tap, horseshoe	6.40
L3570	Miscellaneous shoe addition, special extension to instep (leather with eyelets)	152.00

L3580	Miscellaneous shoe addition, convert instep to velcro closure	13.60
L3590	Miscellaneous shoe addition, convert firm shoe counter to soft counter	28.00
L3595	Miscellaneous shoe addition, March bar	12.00
	TRANSFER OR REPLACEMENT	
L3600	Transfer of an orthosis from one shoe to another, caliper plate, existing	48.00
L3610	Transfer of an orthosis from one shoe to another, caliper plate, new	76.00
L3620	Transfer of an orthosis from one shoe to another, solid stirrup, existing	39.04
L3630	Transfer of an orthosis from one shoe to another, solid stirrup, new	76.00
L3640	Transfer of an orthosis from one shoe to another, Dennis Browne splint (Riveton), both shoes	28.00
L3649	Unlisted procedures for foot orthopedic shoes, shoe modifications and transfers	B.R.
X4280	Velcro strap used with orthoses, for each strap	18.00

(f) ORTHOTIC DEVICES—UPPER LIMB (L3650-L3999)

Note: The procedures in this section are considered as "base" or "basic procedures" and may be modified by listing procedures from the "additions" sections and adding them to the base procedure.

	UPPER LIMB: SHOULDER ORTHOSIS (SO)	
L3650	Shoulder othosis, (SO), figure of "8" design abduction restrainer	32.00
L3660	SO, figure of "8" design abduction restrainer, canvas and webbing	60.00
L3670	SO, acromion/clavicular (canvas and webbing type)	88.62
	UPPER LIMB: ELBOW ORTHOSIS (EO)	
L3700	Elbow orthoses (EO), elastic with stays	36.00
L3710	EO, elastic with metal joints	60.00
L3720	EO, double upright with forearm/arm cuffs, free motion	520.00
L3730	EO, double upright with forearm/arm cuffs, extension/flexion assist	617.71
L3740	EO, double upright with forearm/arm cuffs, adjustable position with lock with active control	692.08
	UPPER LIMB: WRIST-HAND-FINGER ORTHOSIS (WHFO)	
L3800	Wrist-hand-finger-orthoses (WHFO), short opponens, no attachments	124.28
L3805	WHFO, long opponens, no attachment	240.00
	ADDITIONS	
L3810	WHFO, addition to short and long opponens, thumb abduction ("C") bar	28.00
L3815	WHFO, addition to short and long opponens, second M.P. abduction assist	28.00
L3820	WHFO, addition to short and long opponens, I.P. extension assist, with M.P. extension stop	60.00
L3825	WHFO, addition to short and long opponens, M.P. extension stop	28.00
L3830	WHFO, addition to short and long opponens, M.P. extension assist	44.00
L3835	WHFO, addition to short and long opponens, M.P. spring extension assist	60.00
L3840	WHFO, addition to short and long opponens, spring swivel thumb	32.00
L3845	WHFO, addition to short and long opponens, thumb I.P. extension assist, with N.P. stop	36.00
L3850	WHFO, addition to short and long opponens, action wrist, with dorsiflexion assist	64.00
L3855	WHFO, addition to short and long opponens, adjustable M.P. flexion control	75.81
L3860	WHFO, addition to short and long opponens, adjustable M.P. flexion control and I.P.	103.17
	DYNAMIC FLEXOR HINGE, RECIPROCAL WRIST EXTENSION/FLEXION, FINGER FLEXION/EXTENSION	
L3900	WHFO, dynamic flexor hinge; reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven	800.00
L3901	WHFO, dynamic flexor hinge; reciprocal wrist extension/flexion, finger flexion/extension, cable driven	884.00
	EXTERNAL POWER	
L3902	WHFO, external powered, compressed gas	369.00
L3904	WHFO, external powered, electric	369.00
	OTHER WHFO'S—CUSTOM FITTED	
L3906	WHFO, wrist gauntlet, molded to patient model	267.41
L3907	WHFO, wrist gauntlet with thumb spica, molded to patient model	B.R.
L3908	WHFO, wrist extension control cock-up, nonmolded	50.13
L3910	WHFO, Swanson design	216.00
L3912	WHFO, flexion glove with elastic finger control	67.25
L3914	WHFO, wrist extension cock-up	60.00
L3916	WHFO, wrist extension cock-up, with outrigger	72.00
L3918	WHFO, knuckle bender	50.45
L3920	WHFO, knuckle bender, with outrigger	60.00
L3922	WHFO, knuckle bender, two segment to flex joints	63.54
L3924	WHFO, Oppenheimer	60.00
L3926	WHFO, Thomas suspension	64.00
L3928	WHFO, finger extension, with clock spring	40.00
L3930	WHFO, finger extension, with wrist support	44.79
L3932	WHFO, safety pin, spring wire	29.94
L3934	WHFO, safety pin, modified	31.24
L3936	WHFO, Palmer	48.00
L3938	WHFO, dorsal wrist	48.00
L3940	WHFO, dorsal wrist, with outrigger attachment	60.00
L3942	WHFO, reverse knuckle bender	48.40
L3944	WHFO, reverse knuckle bender, with outrigger	60.00
L3946	WHFO, composite elastic	57.63
L3948	WHFO, finger knuckle bender	36.00
L3950	WHFO, combination Oppenheimer, with knuckle bender and two attachments	96.00
L3952	WHFO, combination Oppenheimer, with reverse knuckle and two attachments	96.00
L3954	WHFO, spreading hand	52.00
	UPPER LIMB: SHOULDER—ELBOW—WRIST—HAND ORTHOSIS (SEWHO)—ABDUCTION POSITIONING—CUSTOM FITTED	
L3960	Shoulder-elbow-wrist-hand orthosis (SEWHO), abduction positioning, airplane design	460.00
L3962	SEWHO, abduction positioning, Erbs Palsey design	420.00
L3963	SEWHO, molded shoulder, arm, forearm, and wrist, with articulating elbow joint	847.70
L3964	SEWHO, mobil arm support attached to wheelchair, balanced and fitted to patient, adjustable	520.00

L3965	SEWHO, radial arm support attached to wheelchair, balanced and fitted to patient, adjustable rancho type	759.66
L3966	SEWHO, mobil arm support attached to wheelchair, balanced and fitted to patient, reclining	488.00
L3968	SEWHO, mobil arm support attached to wheelchair, balanced and fitted to patient, friction arm support (friction dampening to proximal and distal joints)	680.00
L3969	SEWHO, mobil arm support, monosuspension arm and hand support, overhead elbow foream hand sling support, yoke type arm suspension support	417.06
	ADDITIONS TO MOBILE ARM SUPPORTS	
L3970	SEWHO, addition to mobil arm support, elevating proximal arm	200.00
L3972	SEWHO, addition to mobil arm support, offset or lateral rocker arm with elastic balance control	112.00
L3974	SEWHO, addition to mobil arm support, supinator	112.00
	UPPER LIMB—FRACTURE ORTHOSIS	
L3980	Upper extremity fracture orthosis, humeral	163.17
L3982	Upper extremity fracture orthosis, radius/ulnar	172.00
L3984	Upper extremity fracture orthosis, wrist	122.40
L3985	Upper extremity fracture orthosis, forearm, hand with wrist hinge	366.12
L3986	Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist, (example: Colles fracture)	391.85
L3995	Addition to upper extremity orthosis, sock, fracture or equal, each	14.80
L3999	Unlisted procedures for upper limb orthosis	B.R.
	(g) SPECIFIC REPAIR (L4000-L4199)	
L4000	Replace girdle for Milwaukee orthosis	696.00
L4010	Replace trilateral socket brim	444.59
L4020	Replace quadrilateral socket brim, molded to patient model	532.00
L4030	Replace quadrilateral socket brim, custom fitted	373.06
L4040	Replace molded thigh lacer	272.53
L4045	Replace nonmolded thigh lacer	140.00
L4050	Replace molded calf lacer	331.80
L4055	Replace nonmolded calf lacer	61.02
L4060	Replace high roll cuff	136.00
L4070	Replace proximal and distal upright for KAFO	168.00
L4080	Replace metal bands KAFO, proximal thigh	72.00
L4090	Replace metal bands KAFO-AFO, calf or distal thigh	60.00
L4100	Replace leather cuff KAFO, proximal thigh	80.00
L4110	Replace leather cuff KAFO-AFO, calf or distal thigh	52.00
L4130	Replace pretibial shell	331.45
X4370	Calf cuff	52.00
X4375	Calf band	34.00
	(h) REPAIRS (L4200—L4299)	
L4200	Repair of orthotic device, hourly rate	42.40
L4210	Repair of orthotic device, repair or replace minor parts	69.00
	(i) ANCILLARY ORTHOTIC SERVICES (L4300—L4399)	
L4310	Multipodus or equal orthotic preparatory management system for lower extremities	200.00
L4320	Addition to AFO, multipodus (or equal) orthotic preparatory management system for lower extremities flexible foot positioner with soft interface for AFO, with velcro closure, custom fitted	72.00
L4350	Pneumatic ankle control splint (for example, aircast)	52.00
L4360	Pneumatic walking splint (for example, aircast)	160.00
L4370	Pneumatic full leg splint (for example, aircast)	88.00
L4380	Pneumatic knee splint (for example, aircast)	56.00
X3680	Travel time per hour (specify time involved)	40.72

10:55-2.4 HCPCS Procedure Codes and Maximum Fee Allowance Schedule for Prosthetic Services

(a) PROSTHETIC PROCEDURES

LOWER LIMB (L5000—L5999)

The procedures in this section are considered as "base" or "basic procedures" and may be modified by listing items/procedures or special material from the "additions" section and adding them to the base procedure.

	PARTIAL FOOT	
L5000	Partial foot, shoe insert with longitudinal arch, toe filler	339.53
L5010	Partial foot, molded socket, ankle height, with toe filler	680.00
L5020	Partial foot, molded socket, tibial tubercle height, with toe filler	1,040.00
	ANKLE	
L5050	Ankle, Syme, molded socket, Sach foot	1,360.00
L5060	Ankle, Syme, metal frame, molded leather socket, articulated ankle/foot	2,000.00
	BELOW KNEE	
L5100	Below knee, molded socket, shin, Sach foot	1,036.56
L5105	Below knee, plastic socket, joints and thigh lacer, Sach foot	2,000.00
	KNEE DISARTICULATION	
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, Sach foot	2,500.00
L5160	Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, Sach foot	2,683.30
	ABOVE KNEE	
L5200	Above knee, molded socket, single axis constant friction knee, shin, Sach foot	1,301.76
L5210	Above knee, short prosthesis, no knee joint ("stubbies"), with foot blocks, no ankle joints, each	1,360.00
L5220	Above knee, short prosthesis, no knee joint ("stubbies"), with articulated ankle/foot, dynamically aligned, each	1,680.00
L5230	Above knee, for proximal femoral focal deficiency, constant friction knee, shin, Sach foot	1,607.20
	HIP DISARTICULATION	
L5250	Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, Sach foot	3,040.00
L5270	Hip disarticulation, tilt table type, molded socket, locking hip joint, single axis constant friction knee, shin, Sach foot	3,040.00
	HEMIPELVECTOMY	
L5280	Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, Sach foot	3,440.00

	ENDOSKELETAL: BELOW KNEE	
L5300	Below knee, molded socket, Sach foot, endoskeletal system, including soft cover and finishing	1,379.04
	ENDOSKELETAL: KNEE DISARTICULATION	
L5310	Knee disarticulation (or through knee), molded socket, Sach foot endoskeletal system, including soft cover and finishing	2,800.00
	ENDOSKELETAL: ABOVE KNEE	
L5320	Above knee, molded socket, open end, Sach foot, endoskeletal system, single axis knee, including soft cover and finishing	1,610.96
	ENDOSKELETAL: HIP DISARTICULATION	
L5330	Hip disarticulation, Canadian type; molded socket, endoskeletal system, single axis knee, hip joint, Sach foot, including soft cover and finishing	2,800.00
	ENDOSKELETAL: HEMIPELVECTOMY	
L5340	Hemipelvectomy, Canadian type; molded socket, endoskeletal system, single axis knee, hip joint, Sach foot, including soft cover and finishing	4,000.00
	IMMEDIATE POSTSURGICAL OR EARLY FITTING PROCEDURES	
L5400	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee	844.78
L5410	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment	328.42
L5420	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change "AK" or knee disarticulation	1,070.47
L5430	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, "AK" or knee disarticulation, each additional cast change and realignment	461.40
L5450	Immediate postsurgical or early fitting, application of nonweight bearing rigid dressing, below knee	200.00
L5460	Immediate postsurgical or early fitting, application of nonweight bearing rigid dressing, above knee	240.00
	INITIAL PROSTHESIS	
L5500	Initial, below knee "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, plaster socket, direct formed	726.60
L5505	Initial, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot plaster socket, direct formed	980.00
	PREPARATORY PROSTHESIS	
L5510	Preparatory, below knee "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, plaster socket, molded to model	726.60
L5520	Preparatory, below knee "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, thermoplastic or equal, direct formed	960.00
L5530	Preparatory, below knee "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, thermoplastic or equal, molded to model	1,120.00
L5535	Preparatory, below knee "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, prefabricated, adjustable open end socket	1,000.00
L5540	Preparatory, below knee "PTB" type socket, "USMC" or equal pylon, no cover, Sach foot, laminated socket, molded to model	1,146.60
L5560	Preparatory, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot, plaster socket, molded to model	1,120.00
L5570	Preparatory, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot, thermoplastic or equal, direct formed	1,200.00
L5580	Preparatory, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover Sach foot, thermoplastic or equal, molded to model	1,320.00
L5585	Preparatory, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot, prefabricated adjustable open end socket	1,248.88
L5590	Preparatory, above knee—knee disarticulation, ischial level socket, "USMC" or equal pylon, no cover, Sach foot, laminated socket, molded to model	1,499.40
L5595	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, Sach foot, thermoplastic or equal, molded to patient model	2,120.00
	ADDITIONS TO LOWER EXTREMITY	
L5600	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, Sach foot, laminated socket, molded to patient model	2,240.00
L5610	Addition to lower extremity, above knee, hydracadence system	1,454.31
L5611	Addition to lower extremity, above knee—knee disarticulation, 4-bar linkage, with friction swing phase control	768.00
L5613	Addition to lower extremity, above knee—knee disarticulation, 4-bar linkage, with hydraulic swing phase control	1,240.00
L5614	Addition to lower extremity, above knee—knee disarticulation, 4-bar linkage, with pneumatic swing phase control	2,307.16
L5616	Additions to lower extremity, above knee, universal multiplex system, friction swing phase control	720.00
	ADDITIONS: TEST SOCKETS	
L5618	Addition to lower extremity, test socket, Symes	160.00
L5620	Addition to lower extremity, test socket, below knee	208.63
L5622	Addition to lower extremity, test socket, knee disarticulation	264.00
L5624	Addition to lower extremity, test socket, above knee	240.00
L5626	Addition to lower extremity, test socket, hip disarticulation	300.00
L5628	Addition to lower extremity, test socket, hemipelvectomy	340.00
L5629	Addition to lower extremity, below knee, acrylic socket	289.07
	ADDITIONS: SOCKET VARIATIONS	
L5630	Addition to lower extremity, Symes type, expandable wall socket	280.00
L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic socket	320.00

L5632	Addition to lower extremity, Symes type, "PTB" brim design socket	180.02
L5634	Addition to lower extremity, Symes type, posterior opening (Canadian) socket	231.74
L5636	Addition to lower extremity, Symes type, medial opening socket	196.85
L5637	Addition to lower extremity, below knee, total contact	160.00
L5638	Addition to lower extremity, below knee, leather socket	320.00
L5639	Addition to lower extremity, below knee, wood socket	600.00
L5640	Addition to lower extremity, knee disarticulation, leather socket	400.00
L5642	Addition to lower extremity, above knee, leather socket	400.00
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame	691.20
L5644	Addition to lower extremity, above knee, wood socket	400.00
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame	325.44
L5646	Addition to lower extremity, below knee, air cushion socket	260.00
L5647	Addition to lower extremity, below knee, suction socket	223.74
L5648	Addition to lower extremity, above knee, air cushion socket	300.00
L5649	Addition to lower extremity, ischial containment/ narrow M-L socket	1,354.99
L5650	Addition to lower extremity, total contact, above knee or knee disarticulation socket	354.91
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame	528.84
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket	310.53
L5653	Addition to lower extremity, knee disarticulation, expandable wall socket	408.96
X3435	Socket-thigh component, total contact above knee	607.00
	ADDITIONS: SOCKET INSERT AND SUSPENSION	
L5654	Addition to lower extremity, socket insert, Symes (Kemblo, Pelite, Aliplast, Plastazote or equal)	231.71
L5655	Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal)	184.80
L5656	Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal)	273.00
L5658	Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal)	259.38
L5660	Addition to lower extremity, socket insert, Symes, silicone gel or equal	320.00
L5661	Addition to lower extremity, socket insert, multi-durometer, Symes	438.84
L5662	Addition to lower extremity, socket insert, below knee, silicone gel or equal	300.00
L5663	Addition to lower extremity, socket insert, knee disarticulation, silicone gel or equal	380.00
L5664	Addition to lower extremity, socket insert, above knee, silicone gel or equal	380.00
L5665	Addition to lower extremity, socket insert, multidurometer, below knee	223.74
L5666	Addition to lower extremity, below knee, cuff suspension	40.72
L5667	Addition to lower extremity, below knee, socket insert, suction suspension, with locking mechanism	909.03
L5668	Addition to lower extremity, below knee, molded distal cushion	77.53
L5669	Addition to lower extremity, below knee, socket insert, suction suspension, without locking mechanism	697.05
L5670	Addition to lower extremity, below knee, molded supracondylar suspension ("PTS" or similar)	199.00
L5672	Addition to lower extremity, below knee, removable medial brim suspension	220.00
X3540	Suction socket valve	79.76
L5674	Addition to lower extremity, below knee, latex sleeve suspension or equal, each	44.28
L5675	Addition to lower extremity, below knee, latex sleeve suspension or equal, heavy duty, each	40.68
L5676	Addition to lower extremity, below knee, knee joints, single axis, pair	178.96
L5677	Addition to lower extremity, below knee, knee joints, polycentric, pair	203.40
L5678	Addition to lower extremity, below knee joint covers, pair	20.00
L5680	Addition to lower extremity, below knee, thigh lacer, nonmolded	172.88
L5682	Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded	420.00
L5684	Addition to lower extremity, below knee, fork strap	32.56
L5686	Addition to lower extremity, below knee, back check (extension control)	32.00
L5688	Addition to lower extremity, below knee, waist belt, webbing	40.72
L5690	Addition to lower extremity, below knee, waist belt, padded and lined	71.62
L5692	Addition to lower extremity, above knee, pelvic control belt, light	69.20
L5694	Addition to lower extremity, above knee, pelvic control belt, padded and lined	125.53
L5695	Addition to lower extremity, below knee, pelvic control, sleeve suspension, neoprene or equal, sach	100.00
L5696	Addition to lower extremity, above knee or knee disarticulation, pelvic joint	140.00
L5697	Addition to lower extremity, above knee or knee disarticulation, pelvic band	32.56
L5698	Addition to lower extremity, above knee or knee disarticulation, silesian bandage	72.40
L5699	All lower extremity prostheses, shoulder harness	113.40
X3001	Tees pelvic suspensory	125.00
	REPLACEMENTS/ADDITIONS: EXOSKELETAL KNEE-SHIN SYSTEM	
L5700	Replacement, socket, below knee, molded to patient model	1,549.30
L5701	Replacement, socket, above knee-knee disarticulation, including attachment plate, molded to patient model	1,922.04
L5702	Replacement, socket, hip disarticulation, including hip joint, molded to patient model	2,422.44
L5704	Replacement, custom shaped protective cover, below knee	315.89
L5705	Replacement, custom shaped protective cover, above knee	579.14

L5706	Replacement, custom shaped protective cover, knee disarticulation	564.88
L5707	Replacement, custom shaped protective cover, hip disarticulation	758.92
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock	174.96
L5711	Addition, exoskeletal knee-shin system, single axis, manual lock, ultra-light material	284.80
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	252.00
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control (safety knee)	280.00
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock	420.00
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control	420.00
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	633.19
X3002	Quarting foot	700.00
X3610	"D" Rings	12.24
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	880.00
L5726	Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control	1,000.00
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control	1,540.00
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control	600.00
	COMPONENT MODIFICATION	
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	203.40
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	305.10
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	406.80
	ENDOSKELETAL	
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock	264.62
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material	325.44
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	284.80
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock	386.46
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control	552.00
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	1,120.00
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control	610.20
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control	1,440.00
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control	1,076.00
L5840	Addition, endoskeletal knee-shin system, multi-axial, pneumatic/swing phase control	1,262.80
L5850	Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist	64.80
L5855	Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist	171.52
L5910	Addition, endoskeletal system, below knee, alignable system	280.25
L5920	Addition, endoskeletal system, above knee or hip disarticulation, alignable system	252.00
L5925	Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock	186.61
L5940	Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	224.00
L5950	Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	500.00
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	467.82
L5962	Addition, endoskeletal system, below knee, flexible protective outer surface covering system	326.45
L5964	Addition, endoskeletal system, above knee, flexible protective outer surface covering system	566.20
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system	729.36
L5970	All lower extremity prostheses, foot, external keel, Sach foot	78.40
L5972	All lower extremity prostheses, flexible keel foot (Safe, Sten, Bock Dynamic or equal)	122.40
L5974	All lower extremity prostheses, foot, single axis ankle/foot	109.60
L5976	All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)	284.80
L5978	All lower extremity prostheses, foot, multi-axial ankle/foot	135.20
L5979	All lower extremity prostheses, multi-axial ankle/foot, dynamic response	1,267.27
L5980	All lower extremity prostheses, flex-foot system	2,033.60
L5981	All lower extremity prostheses, flex-walk system or equal	1,723.48
L5982	All exoskeletal lower extremity prostheses, axial rotation unit	406.40
L5984	All endoskeletal lower extremity prostheses, axial rotation unit	304.80
L5986	All lower extremity prostheses, multi-axial rotation unit ("MCP" or equal)	304.80
L5999	Unlisted procedures for lower extremity prosthesis	B.R.

(b) UPPER LIMB (L6000—L6699)

The procedures in L6000—L6599 are base procedures which may be modified by listing procedures form the "additions" sections. The base procedures include only standard friction wrist and control cable system, unless otherwise specified.

	PARTIAL HAND	
L6000	Partial hand, Robin-aids, thumb remaining (or equal)	924.32
L6010	Partial hand, Robin-aids, little and/or ring finger remaining (or equal)	1,000.00
L6020	Partial hand, Robin-aids, no finger remaining (or equal)	953.27
	WRIST DISARTICULATION	
L6050	Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad	1,120.00
L6055	Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad	1,287.00

BELOW ELBOW

L6100 Below elbow, molded socket, flexible elbow hinge, triceps pad 1,120.00

L6110 Below elbow, molded socket, (Muenster or Northwestern suspension types) 1,420.00

L6120 Below elbow, molded double wall split socket, step-up hinges, half cuff 1,520.00

L6130 Below elbow, molded double wall split socket, stump activated locking hinge, half cuff 1,975.33

ELBOW DISARTICULATION

L6200 Elbow disarticulation, molded socket, outside locking hinge, forearm 1,504.00

L6205 Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm 2,522.40

ABOVE ELBOW

L6250 Above elbow, molded double wall socket, internal locking elbow, forearm 1,760.00

SHOULDER DISARTICULATION

L6300 Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow forearm 2,120.00

L6310 Shoulder disarticulation, passive restoration (complete prosthesis) 1,840.00

L6320 Shoulder disarticulation, passive restoration (shoulder cap only) 1,200.00

INTERSCAPULAR THORACIC

L6350 Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm 2,380.00

L6360 Interscapular thoracic, passive restoration (complete prosthesis) 1,545.84

L6370 Interscapular thoracic, passive restoration (shoulder cap only) 1,400.00

IMMEDIATE AND EARLY POST SURGICAL PROCEDURES

L6380 Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow 691.56

L6382 Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow 813.60

L6384 Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic 976.00

L6386 Immediate postsurgical or early fitting, each additional cast change and realignment 223.74

L6388 Immediate postsurgical or early fitting, application of rigid dressing only 203.40

ENDOSKELETAL: BELOW ELBOW

L6400 Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping 1,204.00

ENDOSKELETAL: ELBOW DISARTICULATION

L6450 Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping 1,301.60

ENDOSKELETAL: ABOVE ELBOW

L6500 Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping 1,512.00

ENDOSKELETAL: SHOULDER DISARTICULATION

L6550 Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping 1,760.00

ENDOSKELETAL: INTERSCAPULAR THORACIC

L6570 Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping 2,160.00

L6580 Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowen cable control, "USMC" or equal pylon, no cover, molded to patient model 813.60

L6582 Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowen cable control, "USMC" or equal pylon, no cover, direct formed 691.56

L6584 Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model 1,159.38

L6586 Preparatory, elbow disarticulation or below elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, humeral cuff, fair lead cable control, "USMC" or equal pylon, no cover, direct formed 996.66

L6588 Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model 1,732.80

L6590 Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, direct formed 1,586.40

ADDITIONS: UPPER LIMB

The following procedures/modifications/components may be added to other base procedures. The items in this section should reflect the additional complexity of each modification procedure, in addition to base procedure, at the time of the original order.

L6600 Upper extremity additions, polycentric hinge, pair 52.00

L6605 Upper extremity additions, single pivot hinge, pair 116.00

L6610 Upper extremity additions, flexible metal hinge, pair 46.00

L6615 Upper extremity addition, disconnect locking wrist unit 60.00

L6616 Upper extremity addition, additional disconnect insert for locking wrist unit, each 59.89

L6620 Upper extremity addition, flexion-friction wrist unit 211.56

L6623 Upper extremity addition, spring assisted rotational wrist unit with latch release 386.40

L6625 Upper extremity addition, rotation wrist unit with cable lock 160.00

L6628 Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal 284.76

L6629	Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal	73.22
L6630	Upper extremity addition, stainless steel, any wrist	68.00
L6632	Upper extremity addition, latex suspension sleeve, each	32.54
L6635	Upper extremity addition, lift assist for elbow	152.48
L6637	Upper extremity addition, nudge control elbow lock	251.68
L6640	Upper extremity additions, shoulder abduction joint, pair	130.40
L6641	Upper extremity addition, excursion amplifier, pulley type	97.60
L6642	Upper extremity addition, excursion amplifier, lever type	138.40
L6645	Upper extremity addition, shoulder flexion-abduction joint, each	65.00
L6650	Upper extremity addition, shoulder universal joint, each	200.00
L6655	Upper extremity addition, standard control cable, extra	35.00
L6660	Upper extremity addition, heavy duty control cable	56.00
L6665	Upper extremity addition, Teflon, or equal, cable lining	24.00
L6670	Upper extremity addition, hook to hand, cable adapter	43.40
L6672	Upper extremity addition, harness, chest or shoulder, saddle type	108.00
L6675	Upper extremity addition, harness, figure of ("8") eight type, for single control	80.42
L6676	Upper extremity addition, harness, figure of ("8") eight type, for dual control	86.32
L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow	160.00
L6682	Upper extremity addition, test socket, elbow disarticulation or above elbow	180.00
L6684	Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic	148.00
L6686	Upper extremity addition, suction socket	406.80
L6687	Upper extremity addition, frame type socket, below elbow or wrist disarticulation	244.08
L6688	Upper extremity addition, frame type socket, above elbow or elbow disarticulation	284.76
L6689	Upper extremity addition, frame type socket, shoulder disarticulation	325.60
L6690	Upper extremity addition, frame type socket, interscapular-thoracic	366.40
L6691	Upper extremity addition, removable insert, each	244.08
L6692	Upper extremity addition, silicone gel insert or equal, each	240.00
	(c) TERMINAL DEVICES—HOOKS (L6700—L6899)	
L6700	Terminal device, hook, Dorrance or equal, model #3	265.00
L6705	Terminal device, hook, Dorrance or equal, model #5	211.67
L6710	Terminal device, hook, Dorrance or equal, model #5X	240.00
L6715	Terminal device, hook, Dorrance or equal, model #5XA	226.00
L6720	Terminal device, hook, Dorrance or equal, model #6	591.22
L6725	Terminal device, hook, Dorrance or equal, model #7	288.69
L6730	Terminal device, hook, Dorrance or equal, model #7LO	350.00
L6735	Terminal device, hook, Dorrance or equal, model #8	208.02
L6740	Terminal device, hook, Dorrance or equal, model #8X	215.69
L6745	Terminal device, hook, Dorrance or equal, model #88X	220.00
L6750	Terminal device, hook, Dorrance or equal, model #10P	195.58
L6755	Terminal device, hook, Dorrance or equal, model #10X	270.00
L6765	Terminal device, hook, Dorrance or equal, model #12P	203.81
L6770	Terminal device, hook, Dorrance or equal, model #99X	245.45
L6775	Terminal device, hook, Dorrance or equal, model #555	288.51
L6780	Terminal device, hook, Dorrance or equal, model #SS555	243.20
L6790	Terminal device, hook, Accu hook or equal	300.80
L6795	Terminal device, hook, 2 load or equal	750.00
L6800	Terminal device, hook, APRL VC or equal	700.00
L6805	Terminal device, modifier wrist flexion unit	248.00
L6806	Terminal device, hook, TRS Grip, VC	915.81
L6807	Terminal device, hook, TRS Adept, child, VC	696.18
L6808	Terminal device, hook, TRS adept, infant, VC	581.43
L6809	Terminal device, hook, TRS Super Sport, passive	253.74
L6810	Terminal device, pincher tool, Otto Bock or equal	104.24
	HANDS	
L6825	Terminal device, hand, Dorrance, VO	700.00
L6830	Terminal device, hand, APRL, VC	780.00
L6835	Terminal device, hand, Sierra, VO	680.00
L6840	Terminal device, hand, Becker Imperial	525.00
L6845	Terminal device, hand, Becker Lock Grip	460.00
L6850	Terminal device, hand, Becker Plylite	460.00
L6855	Terminal device, hand, Robin-aids, VO	480.00
L6860	Terminal device, hand, Robin-aids, VO soft	400.00
L6865	Terminal device, hand, Passive Hand	168.00
L6867	Terminal device, hand, Detroit Infant Hand (mechanical)	618.06
L6868	Terminal device, hand, Passive Infant Hand, Steeper, Hosmer or equal	136.97
L6870	Terminal device, hand, child mitt	140.00
L6872	Terminal device, hand, NYU child hand	615.38
L6873	Terminal device, hand, mechanical infant hand, Steeper or equal	257.50
L6875	Terminal device, hand, Bock, VC	540.00
L6880	Terminal device, hand, Bock, VO	320.00
	GLOVES FOR ABOVE HANDS	
L6890	Terminal device, glove for above hands, production glove	84.00
L6895	Terminal device, glove for above hands, custom glove	296.00
	(d) HAND RESTORATION (L6900-L6999)	
L6900	Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining	1,000.00

L6905	Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining	1,000.00
L6910	Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining	1,000.00
L6915	Hand restoration (shading and measurements included), replacement glove for above	320.00
	EXTERNAL POWER—BASE DEVICES	
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	3,789.90
L6925	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	4,350.58
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	3,807.50
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	4,384.65
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	5,210.69
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	5,780.01
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow forearm, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	5,761.18
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	6,850.89
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow forearm, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	6,950.69
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal, electrodes, cables, two batteries and one charger myoelectronic control of terminal device	7,934.50
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	8,475.55
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	9,418.54
	(e) EXTERNAL POWER—TERMINAL DEVICES (L7000—L7499)	
L7010	Electronic hand, Otto Bock, Steeper or equal, switch controlled	1,982.40
L7015	Electronic hand, System Teknik, Variety Village or equal, switch controlled	3,307.05
L7020	Electronic greifer, Otto Bock or equal, switch controlled	2,071.86
L7025	Electronic hand, Otto Bock or equal, myoelectronically controlled	2,076.36
L7030	Electronic hand, System Teknik, Variety Village or equal, myoelectronically controlled	3,443.55
L7035	Electronic greifer, Otto Bock or equal, myoelectronically controlled	2,014.85
L7040	Prehensile actuator, Hosmer or equal, switch controlled	1,616.36
L7045	Electronic hook, child, Michigan or equal, switch controlled	854.01
	EXTERNAL POWER—ELBOW	
L7160	Electronic elbow, Boston or equal, switch controlled	8,938.22
L7165	Electronic elbow, Boston or equal, myoelectronically controlled	10,015.91
L7170	Electronic elbow, Hosmer or equal, switch controlled	3,238.90
L7180	Electronic elbow, Utah or equal, myoelectronically controlled	19,382.46
L7185	Electronic elbow, adolescent, Variety Village or equal, switch controlled	3,625.58
L7186	Electronic elbow, child, Variety Village or equal, switch controlled	4,800.00
L7190	Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled	5,177.71
L7191	Electronic elbow, child, Variety Village or equal, myoelectronically controlled	5,072.00
L7260	Electronic wrist rotator, Otto Bock or equal	1,342.44
L7261	Electronic wrist rotator, for Utah arm	2,000.62
L7266	Servo control, Steeper or equal	554.90
L7272	Analogue control, UNB or equal	1,216.24
L7274	Proportional control, 12 volt, Utah or equal	3,666.11
	EXTERNAL POWER—BATTERY COMPONENTS	
L7360	Six volt battery, Otto Bock or equal, each	167.90
L7362	Battery charger, six volt, Otto Bock or equal	150.23
L7364	Twelve volt battery, Utah or equal, each	296.74
L7366	Battery charger, twelve volt, Utah or equal	398.67
L7499	Unlisted procedures for upper extremity prosthesis	B.R.
	(f) REPAIRS (L7500—L7599)	
L7500	Repair of prosthetic device, hourly rate	40.72
L7510	Repair prosthetic device, repair or replace minor parts	B.R.
X3680	Travel time per hour (specify time involved)	40.72
X3690	Consultation without provision of an appliance (prosthetics or orthotics)	30.00

(g) GENERAL (L8000—L8399)

BREAST PROSTHESES

L8000	Breast prosthesis, mastectomy bra	16.00
L8010	Breast prosthesis, mastectomy sleeve	40.56
L8020	Breast prosthesis, mastectomy form	132.00
L8030	Breast prosthesis, silicone or equal	125.60
X3650	Breast prosthesis, insert type	63.20

ELASTIC SUPPORTS

L8100	Elastic support, elastic stocking, below knee, medium weight, each	24.00
L8110	Elastic support, elastic stocking, below knee, heavy weight, each	30.40
L8120	Elastic support, elastic stocking, below knee, surgical weight, (Linton type or equal), each	32.00
L8130	Elastic support, elastic stocking, above knee, medium weight, each	33.60
L8140	Elastic support, elastic stocking, above knee, heavy weight, each	36.00
L8150	Elastic support, elastic stocking, above knee, surgical weight, (Linton type or equal), each	44.00
L8160	Elastic support, elastic stocking, full-length, medium weight, each	40.00
L8170	Elastic support, elastic stocking, full-length, heavy weight, each	48.00
L8180	Elastic support, elastic stocking, full-length, heavy surgical weight, (Linton type or equal), each	52.00
L8190	Elastic support, elastic stocking, leotards, medium weight, each	108.00
L8200	Elastic support, elastic stocking, leotards, surgical weight, (Linton type), each	120.00
L8210	Elastic support, elastic stocking, custom-made	B.R.
L8220	Elastic support, elastic stocking, lymphedema	B.R.
L8230	Elastic support, elastic stocking, garter belt	B.R.

TRUSSES

L8300	Truss, single with standard pad	51.28
L8310	Truss, double with standard pads	101.68
L8320	Truss, addition to standard pad, water pad	24.00
L8330	Truss, addition to standard pad, scrotal pad	33.65

(h) PROSTHETIC SOCKS (L8400—L8499)

L8400	Prosthetic sheath, below knee, each	12.00
L8410	Prosthetic sheath, above knee, each	12.00
L8415	Prosthetic sheath, upper limb, each	11.20
L8420	Prosthetic sock, wool, below knee, each	14.94
L8430	Prosthetic sock, wool, above knee, each	18.40
L8435	Prosthetic sock, wool, upper limb, each	8.14
L8440	Prosthetic shrinker, below knee, each	33.60
L8460	Prosthetic shrinker, above knee, each	41.60
L8465	Prosthetic shrinker, upper limb, each	33.60
L8470	Stump sock, single ply, fitting, below knee, each	2.52
L8480	Stump sock, single ply, fitting, above knee, each	2.52
L8485	Stump sock, single ply, fitting, upper limb, each	6.21
L8490	Addition to prosthetic sheath/sock, air seal suction retention system	88.68
L8499	Unlisted procedure for miscellaneous prosthetic services	B.R.

APPENDIX A
FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

UNISYS
P.O. Box 4801
Trenton, New Jersey 08619-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN-049
Trenton, New Jersey 08625-0049

RULE ADOPTIONS

BANKING

(a)

DIVISION OF REGULATORY AFFAIRS

Net Worth/Mortgage Solicitors

Adopted Amendments: N.J.A.C. 3:38-1.1 and 5.3

Proposed: October 17, 1994 at 26 N.J.R. 4124(b).
Adopted: November 28, 1994 by Elizabeth Randall, Commissioner, Department of Banking.
Filed: November 30, 1994 as R.1994 d.629, **with substantive and technical changes** not requiring additional public notice or comment (see N.J.A.C. 1:30-4.3) **and with portions (N.J.A.C. 3:38-1.10(k) not adopted.**
Authority: N.J.S.A. 17:1-8; 17:11B-13(a).
Effective Date: December 19, 1994.
Expiration Date: September 11, 1997.

Comments were received from the following persons:
1. Samuel J. Damiano, President, New Jersey Council of Savings Institutions
2. David B. Ward, Esq.
3. Timothy J. Good, President, Mortgage Access Corporation
4. Robert M. Jaworski, Esq., Reed Smith Shaw & McClay
5. Mark Mullen, Esq., Wacks, Mullen & Kartzman
6. E. Robert Levy, Esq., Mortgage Bankers Association

Summary of Public Comments and Agency Responses:

COMMENT: Lowering the required net worth for non-profit mortgage bankers located in urban enterprise zones may not be a feasible alternative. As a matter of fairness, the relaxation of the net worth requirement would create an uneven playing field for other mortgage lenders. Further, non-profit organizations may not have the necessary mortgage banking experience, staff or managers to handle residential mortgage loan originations, processing, underwriting and closing. When this is coupled with the proposed relaxation in the net worth requirement, serious difficulties could ensue for non-profit lenders.

RESPONSE: In light of these serious concerns raised by the commenters, the Department has decided not to adopt the part of the proposal which reduces the net worth for specified non-profit corporations to $50,000, and will give the matter further consideration.

COMMENT: Robert M. Jaworski, Esq., commented on the proposed change to N.J.A.C. 3:38-5.3 which states that a solicitor must re-register if he or she changes employment. He commented that a solicitor does not register with the Department, the employing licensee does. Accordingly, he suggested a clarification in this section that it is the licensee, not the employee, who registers with the Department.

RESPONSE: The Department agrees with this comment and has made a minor technical language change upon adoption to make clear it is the employing licensee who is responsible for re-registering.

COMMENT: The increase in registration from $25.00 to $50.00 is too much, given the level of service provided by the Department in registering solicitors in a timely manner.

RESPONSE: By redefining solicitor more narrowly, it is expected that the number of solicitors which a licensee will need to register will be reduced. This will offset to a large degree the increase to industry of the solicitor fee from $25.00 to $50.00. In addition, it will reduce the number of filings the Department will need to process. It is expected that this, along with recent improvements in the Department's computer system, will improve service to the industry in this area. Accordingly, no change is made based on this comment.

COMMENT: The rule as proposed could be construed to require registration for salaried employees who receive a bonus based on overall performance, not just on mortgage loan applications, mortgage loan closings or other mortgage loan activity. Unless this ambiguity is clarified, the industry may still need to register such salaried employees, thereby frustrating the intent of the proposed change.

RESPONSE: The Department is of the view that salaried employees who receive a bonus based on the dollar amount or volume of mortgage loan applications, mortgage loan closings or other mortgage loan activity should be registered. By excluding other salaried employees, the Department is aware that many persons who the industry views as solicitors will not be required to be registered under this rule. However, a primary purpose of the solicitor rule is to prevent persons from acting as unlicensed brokers for more than one licensee. Those who receive compensation based on the amount or volume of mortgage loan activity are the class of persons most likely to engage in this practice. Accordingly, these are the persons who will need to be registered under the rule. The Department will monitor compliance under this definition and will consider any necessary changes at a future time.

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

3:38-1.1 Definitions

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

...

"Solicitor" means any person not licensed as a mortgage banker or mortgage broker who is employed as a solicitor by one, and not more than one, licensee, who is subject to the direct supervision and control of that licensee, and who solicits, provides or accepts mortgage loan applications, or assists borrowers in completing mortgage loan applications, and whose compensation is in any way based on the dollar amount or volume of mortgage loan applications, mortgage loan closings or other mortgage loan activity.

...

3:38-1.10 Net Worth/Insolvency

(a)-(j) (No change.)

*[(k) A nonprofit corporation may obtain a license as a mortgage banker and may maintain a license with a minimum of $50,000 tangible net worth so long as:

1. All principal and branch offices are located in an enterprise zone as defined in N.J.S.A. 52:27H-62(a);

2. The non-profit corporation originates each calendar year at least 50 percent of all of its mortgage loans to consumers secured by residential real property located in enterprise zones as defined in N.J.S.A. 52:27H-62(a); and

3. The non-profit corporation demonstrates to the satisfaction of the Commissioner by substantial proof, such as executed contracts, that it has sufficient ability to fund mortgage loans through warehouse agreements, table funding agreements, State or Federal programs or otherwise.]*

3:38-5.3 Registration of solicitors

(a) (No change.)

(b) To register a solicitor, the prospective employing licensee shall send the following to the Department of Banking:

1. (No change.)

2. A $50.00 registration fee which is payable every two years upon renewal. A solicitor who changes employing mortgage banker or broker within the two-year registration period must *[re-register]* ***be re-registered by the new employing licensee*** by filing a new registration form with the $50.00 fee. *[A registrant]* ***The employing licensee*** may obtain a duplicate certificate for $10.00 in the event the original certificate is lost or destroyed.

(c) (No change.)

(d) The registration certificate shall contain the name of the solicitor, the name of the employing licensee, and the address of the principal office of the employing licensee. The employing licensee shall display the registration certificate at the office or work station of the solicitor.

(e) Within 30 calendar days after a solicitor ceases his or her affiliation with a licensee, the licensee shall return the registration certificate to the Department. It is not necessary for a licensee to return the registration certificate of a solicitor who changes from one branch location of the licensee to another branch office of that licensee.

(f) The Commissioner shall refuse to register any person who changes affiliation two or more times in the calendar year if the Commissioner determines that the change is for the purpose of evading the licensing requirements of the Act.

PERSONNEL

(a)

MERIT SYSTEM BOARD

Equal Employment Opportunity and Affirmative Action

Sexual Harassment

Adopted Amendments: N.J.A.C. 4A:2-2.3, 4A:7-1.3, 4A:7-3.3 and 4A:7-3.4

Proposed: September 6, 1994 at 26 N.J.R. 3507(a).
Adopted: November 15, 1994 by the Merit System Board, Linda M. Anselmini, Commissioner, Department of Personnel.
Filed: November 22, 1994 as R.1994 d.618, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 11A:2-6(d), 11A:2-20 and 11A:7-1 et seq.

Effective Date: December 19, 1994.
Expiration Date: September 22, 1997.

Summary of Hearing Officer Recommendations and Agency Responses:

Public hearings concerning this reproposal were held on September 22, September 29 and October 4, 1994. Henry Maurer served as hearing officer. No comments were presented on these proposed amendments, and no recommendations were made by the hearing officer. Five individuals submitted written comments. The record of the public hearings may be reviewed by contacting Janet Share Zatz, Director of Appellate Practices and Labor Relations, Department of Personnel, CN 312, Trenton, New Jersey 08625.

Summary of Public Comments and Agency Responses:

COMMENT: Robert W. Becker, Esq., a representative of the New Jersey Law Enforcement Supervisors Association, and Richard A. Dann, President, Communications Workers of America Local 1085, both commented that the proposed amendment to N.J.A.C. 4A:2-2.3, which includes as a ground for discipline "discrimination, including sexual harassment," requires further definition. Specifically, both Messrs. Becker and Dann stated that the word "discrimination" is vague and, to avoid an arbitrary use of discipline based on a term that is subject to interpretation, urged that this ground for discipline be limited in some way. Mr. Dann also stated that the proposed reference to "sexual harassment" in N.J.A.C. 4A:2-2.3 should include a cross-reference to N.J.A.C. 4A:7-1.3(a) for a definition.

RESPONSE: The Merit System Board agrees that, because of confusion that may surround the meaning of "discrimination," it should be defined to preclude misinterpretations of this term. Some may view discrimination in a generalized fashion, believing it to be any kind of perceived mistreatment. To address this potential problem, the Board believes that a change upon adoption should be made to N.J.A.C. 4A:2-2.3(a)9, not requiring additional public notice and comment. This ground for discipline should be described as "Discrimination that affects equal employment opportunity (as defined in N.J.A.C. 4A:7-1.1), including sexual harassment."

However, the Board does not believe a further definition or cross reference for sexual harassment in N.J.A.C. 4A:2-2.3(a)9 is appropriate. Since a cross reference to N.J.A.C. 4A:7-1.1 will be included in N.J.A.C. 4A:2-2.3(a)9, users of the rules should understand that sexual harassment is to be defined as stated in N.J.A.C. 4A:7. In addition, any further cross references in N.J.A.C. 4A:2-2.3(a)9 would render the rule section unnecessarily wordy.

COMMENT: Mr. Becker expressed concern that the proposed amendments to N.J.A.C. 4A:7-1.3 are not necessary in view of the availability of appeals to the Division on Civil Rights and that these provisions may become the "subject of abuse and misinterpretation."

RESPONSE: N.J.S.A. 11A:7-5(e) requires that the Department of Personnel, through the Division of Equal Employment Opportunity and Affirmative Action (EEO/AA) review employment discrimination complaints. Thus, the Division on Civil Rights is not the only forum for such complaints in the State of New Jersey. In order for the Division of EEO/AA to properly review such complaints and for public agencies to understand their obligations under the law, it is necessary for modifications in legal standards as exemplified in the recent landmark decision of *Lehmann v. Toys 'R' Us, Inc.*, 132 *N.J.* 587 (1993) to be reflected in merit system rules. In addition, the amendments are in accordance with recommendations recently made by the Review Committee on Sexual Harassment (Review Committee).

COMMENT: Mr. Dann commented that, since the *Toys 'R' Us* decision found that sexual harassment is harassment that occurs because of the plaintiff's sex, the reference in N.J.A.C. 4A:7-1.3(a) to "conduct based on gender" is too vague. He suggested that subsection (a) be amended to clarify that sexual harassment is based on the gender of the employees affected.

RESPONSE: The Board agrees with this change and, in view of the technical nature of this change, which would not require additional public notice and comment, has decided to adopt the language change.

COMMENT: Mr. Dann stated that the proposed N.J.A.C. 4A:7-1.3(a)3 is inconsistent with the *Toys 'R' Us* decision because he reads the amendment as prohibiting only intentional conduct and further requiring that the conduct affect the complainant's work performance. He said that the emphasis should be on the nature of the conduct, and he states that this is adequately addressed in the proposed new N.J.A.C. 4A:7-1.3(c). Thus, he suggested that the language in subsection(c) be moved to paragraph (a)3.

RESPONSE: The Board believes that the amendments to N.J.A.C. 4A:7-1.3(a)3 are consistent with the *Toys 'R' Us* decision. The language of paragraph (a)3 states that prohibited conduct at issue need not be intentional to give rise to a claim of sexual harassment. Neither does the language require that work performance be affected, since the language states that a hostile environment alone is enough to state a claim of sexual harassment. Therefore, it is not necessary to change paragraph (a)3. However, the Board believes that language should be added to the end of N.J.A.C. 4A:7-1.3(c), in the form of a technical amendment not requiring additional public notice or comment. to ensure its consistency with paragraph (a)3, concerning the creation of an intimidating, hostile or offensive working environment.

COMMENT: Mr. Dann commented that N.J.A.C. 4A:7-1.3(a)3i should more clearly explain the first example of prohibited conduct in the case of hostile work environment sexual harassment: "generalized gender-based remarks and behavior." He proposed replacing the aforementioned language with "offensive remarks or behavior of a non-sexual nature that are directed at an employee because of the employee's gender (unreasonable criticism, insults, pranks, etc.)."

RESPONSE: The Board does not believe that a change to N.J.A.C. 4A:7-1.3(a)3i is necessary, and plans to adopt that provision as proposed. Since the Board has agreed to change N.J.A.C. 4A:7-1.3(a) to indicate that sexual harassment is defined as specific types of conduct "based on the gender of the employee affected," further amendments along these lines would be superfluous.

COMMENT: Mr. Dann stated that the proposed N.J.A.C. 4A:7-1.3(b) does not clearly indicate how sexual harassment of one employee could give rise to a complaint on the part of another employee. He proposed a change to subsection (b) to state that a hostile work environment is created when an employee not targeted for harassment nevertheless observes it.

RESPONSE: The Board disagrees that a change to N.J.A.C. 4A:7-1.3(b) is necessary. The language in subsection (b) is directly based on one of the holdings of the *Toys 'R' Us* court: "Plaintiff need not personally have been the target of each or any instance of offensive or harassing conduct. Evidence of sexual harassment directed at other women is relevant to both the character of the work environment and its effects on the complainant." See *Toys 'R' Us* at page 611.

COMMENT: Mr. Becker expressed concern that the proposed amendment to N.J.A.C. 4A:7-3.3(a), which would permit an appointing authority to conduct an investigation of a discrimination complaint notwithstanding the proposed 30-day time limitation for appeals, would encourage abuse of the discrimination appeal process. Susan Boehm, Affirmative Action Officer for the Division of Family Development (DFD), Department of Human Services, who stated she was only speaking on her own behalf, expressed concern that appointing authority

investigation of complaints beyond the time limit could lead to discriminatory handling of the complaints.

RESPONSE: The Board does not believe that the language that would permit an appointing authority to investigate discrimination complaints beyond the 30-day time limit would promote abuse of the system, or promote discrimination itself. On the contrary, this language is intended to inform appointing authorities that they should still rectify discriminatory conditions even if the time limit for the formal appeal process has expired. The Board believes that it is important to facilitate a discrimination-free workplace, and permitting an appointing authority to investigate such complaints should advance this goal.

COMMENT: Eileen Shea Pazder, Manager of Human Resources at the Department of Banking, who chaired the Review Committee, commented that proposed amendments to N.J.A.C. 4A:7-3.3(a), concerning the need for proper training of an authorized designee to review sexual harassment complaints, are consistent with the Review Committee's recommendations.

RESPONSE: The Board is pleased to be able to follow the guidelines provided by the Review Committee on such complaints and will adopt N.J.A.C. 4A:7-3.3(a) as proposed.

COMMENT: Valerie L. Holman, President, New Jersey Affirmative Action Officers' Council, commented that the authorized designee selected by the department head, as contemplated in the proposed amendment to N.J.A.C. 4A:7-3.3(a), should be serving in the "affirmative action title series." Such an employee, Ms. Holman stated, is fully trained and experienced in the areas for which the department head's authorized designee may be selected. Using employees in this title series, she said, would save the State training costs. Finally, she suggested that the rules section should require the appointing authority to consult with its Affirmative Action Officer if it is determined that an authorized designee must be utilized. Furthermore, whether the designee or the Affirmative Action Officer conducts the investigation is a matter within the discretion of the department head. See N.J.A.C. 4A:7-3.3(b). It would not be appropriate to amend the rules tolimit the discretion of the department head to determine the best method for investigating a sexual harassment complaint.

RESPONSE: This reproposal includes language clearly providing for the selection of an authorized designee by the department head to investigate a sexual harassment complaint and specifying that this designee possess the necessary expertise to do the investigation. The Board decided to include this language in response to comments made concerning the originally proposed amendments on sexual harassment which appeared in the March 7, 1994 New Jersey Register. See 26 N.J.R. 1182(a). The Board understands and agrees with the need for a designee to be qualified to review such matters, and clear language in the rule concerning selection by the department head ensures that there will be accountability for the selection of the designee. However, the Board disagrees that the designee must emanate from a particular title series. The unique nature of a sexual harassment charge requires some flexibility on the part of the department head to select an individual who is qualified toinvestigate the matter and with whom the complaint feels comfortable in presenting the matter.

COMMENT: Ms. Boehm asked whether the department head's authorized designee would be the same for all amtters in which such a designee is requested or whether the designee would vary from case to case. Ms. Boehm also asked to whom an employee would submit a complaint if the designee varies from case to case.

RESPONSE: The intent of the amendment to N.J.A.C. 4A:7-3.3(a) is that there be one authorized designee for each appointing authority. Further details on the authorized designee will be explained in revised guidelines being prepared by the Department of Personnel on procedures for sexual harassment complaints. The guidelines will be in the form of a handbook which will provide information and advice on handling sexual harassment complaints. The guidelines will not change or add to the requirements as set forth at N.J.A.C. 4A:7.

COMMENT: Ms. Pazder expressed support for the proposed amendment to N.J.A.C. 4A:7-3.3(a)2 which would allow a complainant to initiate a sexual harassment or other discrimination complaint with the Division of EEO/AA under certain circumstances. She stated that this language is consistent with recomendations of the Review Committee.

RESPONSE: The Board appreciates this expression of support and plans to adopt the language in N.J.A.C. 4A:7-3.3(a) 2 as proposed.

COMMENT: Ms. Boehm commented that the 45-day time limit for the department head to render a decision following receipt of the complaint by the Affirmative Action Officer, in N.J.A.C. 4A:7-3.3(b), is too short a timeframe for larger departments to adequately investigate a complaint. She further stated that some complainants may not agree to extend this deadline, as provided in the proposed amendments. She proposed a time limit of 60 days. She also suggested that subsection (b) be further amended to provide for a decision deadline following receipt of the complaint by either the Affirmative Action Officer or the authorized designee of the department head, as the case may be.

RESPONSE: The Board believes that a longer timeframe than 45 days would lengthen the appeal process to an extent that would be unacceptable. Discrimination in the workplace should be investigated and resolved as quickly as possible by an appointing authority. However, the Board agrees that a technical change is necessary to N.J.A.C. 4A:7-3.3(b) to indicate that the department head shall "render a written decision within 45 days of the receipt of the complaint by the Affirmative Action Officer, or authorized designee, as the case may be. . . ." This additional language will help clarify the fact that it is a sexual harassment complainant's option to submit his or her complaint to an authorized designee rather than to the Affirmative Action Officer.

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

4A:2-2.3 General causes

(a) An employee may be subject to discipline for:

1.-7. (No change.)

8. Misuse of public property, including motor vehicles;

9. Discrimination ***that affects equal employment opportunity (as defined in N.J.A.C. 4A:7-1.1)***, including sexual harassment; and

10. Other sufficient cause.

4A:7-1.3 Prohibition of sexual harassment in State government

(a) Sexual harassment is defined as unwelcomed sexual advances, requests for sexual favors and other verbal or physical conduct based on ***the*** gender ***of the employee affected*** when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of employment;

2. Submission to or rejection of such conduct by an employee is used as the basis for employment decisions affecting the employee; or

3. Such conduct has the purpose or effect of unreasonably interfering with an employee's work performance or creating an unreasonably intimidating, hostile or offensive working environment. This type of sexual harassment includes, but is not limited to:

i. Generalized gender-based remarks and behavior;

ii. Inappropriate, unwanted, offensive physical or verbal sexual advances and comments;

iii. Solicitation of sexual activity or other sex-linked behavior by promise of reward;

iv. Coercion of sexual activity by threat of punishment; and

v. Gross sexual imposition such as touching, fondling, grabbing or assault.

(b) The employee need not be a personal target of harassment to file a complaint. The employee instead may show that other employees of the same sex were sexually harassed.

(c) Conduct under (a)3 above by a supervisor, other superior or by coworkers constitutes prohibited sexual harassment when a reasonable person of the same sex in the employee's position would consider it sufficiently severe or pervasive to alter the conditions of employment ***or to create an intimidating, hostile or offensive working environment***.

Recodify existing (b)-(e) as (d)-(g) (No change in text.)

4A:7-3.3 Departmental review: State service

(a) A discrimination complaint shall be presented to the affirmative action officer of the appointing authority, or at the option of the complainant to an authorized designee of the department head in the case of a sexual harassment complaint, with a copy to the Director of the Division of EEO/AA, within 30 days of either the discriminatory action or the date on which complainant should reasonably have known of its occurrence. This time limitation, however, does not preclude the appointing authority from exercising its discretion to conduct its own investigation of a discrimination

complaint. The complaint shall be in writing and specify the basis for the complaint.

1. The authorized designee shall have appropriate training in conducting such investigations.

2. The complainant may present a discrimination complaint directly to the Division of EEO/AA, if filing a complaint with the affirmative action officer would pose a conflict of interest, for example, where the individual against whom the complaint is made is involved in the intake, investigative or decision-making process.

(b) The affirmative action officer, or, in the case of a sexual harassment complaint, either the authorized designee if so directed by the department head or the affirmative action officer, shall investigate the complaint and prepare a report to the department head. The department head shall render a written decision within 45 days of the receipt of the complaint by the affirmative action officer ***or the authorized designee, as the case may be***, unless a longer period is agreed to by the complainant.

1. (No change.)

2. The complainant, the individual against whom the complaint is made, the affirmative action officer and/or the authorized designee who conducted the investigation and the Division of EEO/AA shall be furnished with a copy of the final decision by the department head.

4A:7-3.4 Department of Personnel proceedings: State service

(a) A complainant may appeal a final decision of the department head to the Division of EEO/AA within 20 days of receipt of the decision.

1. If no decision is received within the timeframe specified in N.J.A.C. 4A:7-3.3(b), the complainant may request, in writing, that the Division of EEO/AA assume jurisdiction of the complaint. The Division of EEO/AA shall notify the appointing authority of its action.

2. If probable cause is found, the individual against whom the complaint is made may appeal the decision to the Division of EEO/AA within 20 days of receipt of the probable cause determination but only if no disciplinary action is recommended therein.

Recodify existing 2. and 3. as 3. and 4. (No change in text.)

(b) The complainant may appeal the decision of the Division of EEO/AA to the Merit System Board within 20 days of receipt of the decision.

1.-3. (No change.)

(a)

MERIT SYSTEM BOARD

Selection and Appointment

Approval of Appointments by Department of Personnel

Adopted Amendment: N.J.A.C. 4A:4-1.10

Proposed: September 6, 1994 at 26 N.J.R. 3510(a).

Adopted: November 15, 1994 by the Merit System Board, Linda M. Anselmini, Commissioner, Department of Personnel.

Filed: November 22, 1994 as R.1994 d.619, **without change.**

Authority: N.J.S.A. 11A:2-6(d), 11A:4-1 and 11A:4-8.

Effective Date: December 19, 1994.

Expiration Date: May 12, 1998.

Summary of Hearing Officer Recommendations and Agency Responses:

Public hearings concerning the proposed amendment were held on September 22, September 29 and October 4, 1994. Henry Maurer served as hearing officer. One person, Gloria Church, presented a comment on this proposal at those hearings, and Mr. Maurer recommended that the amendment be adopted as proposed. Written comments were submitted by Mrs. Church and by Robert W. Becker, Esq., representing the New Jersey Law Enforcement Supervisors Association. The record of the public hearings may be reviewed by contacting Janet Share Zatz, Director of Appellate Practices and Labor Relations, Department of Personnel, CN 312, Trenton, New Jersey 08625.

Summary of Public Comments and Agency Responses:

COMMENT: Robert W. Becker, Esq., on behalf of the New Jersey Law Enforcement Supervisors Association, expressed agreement with this proposal, stating that the Commissioner of Personnel should have the power to direct personnel action freezes in connection with layoffs or other emergent circumstances.

RESPONSE: The Merit System Board is pleased with this expression of support for the amendment, and plans to adopt it as proposed.

COMMENT: Gloria Church commented that the new N.J.A.C. 4A:4-1.10(a)1 should be amended to require that the Commissioner direct personnel action freezes in connection with layoffs or other emergent circumstances. She stated that such language would correct inequities in the layoff proces.

RESPONSE: The Board believes that personnel action freezes should be discretionary rather than mandatory. As noted in the proposal, the amendment would clarify the current practice that the Commissioner of Personnel, as part of the Commissioner's appointment approval authority, may impose a personnel action freeze during a layoff or other emergent situation. Requiring that a personnel action freeze be imposed in those situations would unnecessarily restrict the discretion that the Commissioner has to fashion personnel policies tailored to meet the needs of a given situation.

Full text of the adopted amendment follows:

4A:4-1.10 Approval of appointments by Department of Personnel

(a) All initial and subsequent appointments, promotions, and related personnel actions are subject to the review and approval of the Department of Personnel.

1. The Commissioner may direct personnel action freezes in connection with layoffs or other emergent circumstances.

(b) Following submission and review of personnel actions, the appointing authority shall be notified by the Department of Personnel whether the action has been approved or disapproved and the reasons for any disapproval. The appointing authority shall provide written notice to all affected employees of such personnel actions.

(b)

MERIT SYSTEM BOARD

Leaves, Hours of Work and Employee Development Family and Medical Leave

Adopted New Rules: N.J.A.C. 4A:6-1.21, 4A:6-1.21B and 4A:6 Appendix

Adopted Amendments: N.J.A.C. 4A:6-1.1, 1.3, 1.6, 1.8, 1.10 and 1.21; and 4A:8-2.4

Proposed: September 6, 1994 at 26 N.J.R. 3511(a).

Adopted: November 15, 1994 by the Merit System Board, Linda M. Anselmini, Commissioner, Department of Personnel.

Filed: November 22, 1994 as R.1994 d.620, **with technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 34:11B-1 et seq.; N.J.S.A. 11A:2-6(d); N.J.S.A. 11A:6-1 et seq.; 29 U.S.C. 2601 et seq.; and 29 CFR 825 et seq.

Effective Date: December 19, 1994.

Expiration Date: December 22, 1997, N.J.A.C. 4A:6.
January 16, 1995, N.J.A.C. 4A:8.

Summary of Hearing Officer Recommendations and Agency Responses:

Public hearings concerning this proposal were held on September 22, September 29 and October 4, 1994. Henry Maurer served as hearing officer. No comments were presented on these proposed new rules and amendments and no recommendations were made by the hearing officer. Two persons submitted written comments. The record of the public hearings may be reviewed by contacting Janet Share Zatz, Director of Appellate Practices and Labor Relations, Department of Personnel, CN 312, Trenton, New Jersey 08625.

Summary of Public Comments and Agency Responses:

COMMENT: D. Craig Stevens, Director of Personnel, Department of Environmental Protection (DEP), commented that the last sentence of the first paragraph in Example One in N.J.A.C. 4A:6-1.21(b) should be changed, since the proposed N.J.A.C. 4A:6-1.21B(j) provides for the accrual of seniority for State employees on FMLA leave.

RESPONSE: The Merit System Board notes that 29 CFR 825.215 does not entitle an employee on unpaid leave under the Federal Family and Medical Leave Act (FMLA) to continue to accrue seniority. However, in view of language in 29 CFR 825.700(b), which indicates that the FMLA is not intended to discourage employers from adopting more generous leave policies, the Board determined, in this reproposal, to allow for the accrual of seniority by State employees for layoff purposes during unpaid FMLA leave. The Board agrees that, since it plans to adopt N.J.A.C. 4A:6-1.21(B)j, the last sentence in the first paragraph of Example One is misleading and unnecessary and will be deleted upon adoption.

COMMENT: Mr. Stevens proposed that the dates used in Example Eight and Nine be changed, the examples be deleted entirely or that a special note be added indicating that FMLA shall not be applied retroactively.

RESPONSE: The purpose of these examples is to illustrate the different effective dates of the FMLA for two groups of employees, represented and nonrepresented. The FMLA went into effect on August 5, 1993 for nonrepresented employees, but not until February 5, 1994 for represented employees. The interaction between the FLA and FMLA, and the relative rights of represented and nonrepresented employees, are directly affected by these different effective dates.

It is noted that adding language that the FMLA will not apply retroactively would be inappropriate. The FMLA is already in effect as indicated above, and all appointing authorities should already be following that Federal law. This proposal, like the rule concerning the State Family Leave Act (FLA), previously adopted following enactment of the FLA, is for informational purposes only.

COMMENT: Mr. Stevens also suggested that the examples in N.J.A.C. 4A:6-1.21(b) consistently use the terms "State law" or "FLA" and "Federal law" or "FMLA."

RESPONSE: The Board has decided to include technical amendments to N.J.A.C. 4A:6-1.21(a) to clarify that "FLA" refers to State law and "FMLA" refers to Federal law. The Board does not believe that it is necessary, however, to refer to "FLA" and "FMLA" exclusively, or to "State law" and "Federal law" exclusively. In addition, the Board notes that Example Eight should be clarified by indicating that the type of FMLA leave that the employee takes commencing February 10, 1994 is medical leave. The Board has decided to adopt a technical amendment to this effect.

COMMENT: Mr. Stevens recommended that the definition of an employee eligible for FMLA leave be simplified. In particular, he suggested that the hours of service minimum requirements for employee eligibility be further explained.

RESPONSE: The Board is not free to rephrase the definition of FMLA eligibility. It is taken directly from 29 CFR 825.110(c), which states that, whether an employee has worked the minimum of 1,250 hours shall be determined by the "number of hours an employee has worked for the employer within the meaning" of the Federal Fair Labor Standards Act (FLSA), 29 U.S.C. 207. The definition thus also includes the FLSA formula for determining whether an employee has met the minimum threshold of hours for eligibility.

COMMENT: Natalie P. Havran, Director of Human Resources, Department of Transportation, commented that the first sentence of N.J.A.C. 4A:6-1.21B(i) should be changed to state that an "employer may designate an employee's paid leave as FMLA if the information provided by the employee meets the eligibility requirements for such leave." She indicated that the suggested change would clarify that it is the employer's right to determine that a paid leave meets eligibility requirements and to declare it FMLA leave.

RESPONSE: The Board believes that the language as proposed indicates that it is the employer's right to determine that a paid leave is FMLA leave, consistent with 29 CFR 825.208(b). The suggested alternative language would not be entirely accurate, since an employee may be eligible for FMLA leave, but not entitled since this entitlement only exists if the employee needs to take the leave for one of the purposes indicated in N.J.A.C. 4A:6-1.21(d), such as for the birth of a child or the employee's own serious health condition. Thus, substituting the term "eligibility" for "entitlement" may lead to confusion. The Board believes that subsection (i) should track the intent and language of the Federal FMLA regulations, and will adopt (i) as proposed.

COMMENT: Mr. Stevens asked whether, according to the Appendix, the employer may require an employee to substitute paid leave for family leave under State law, since, under the FMLA, the employer may require an employee to substitute paid leave for FMLA leave.

RESPONSE: Under both State and Federal law, an employer is obligated to determine that an employee's leave request falls under one or both leave programs. In fact, the Board proposed, and has decided to adopt, a new N.J.A.C. 4A:6-1.21(a) which explicitly clarifies the existence of this requirement. However, under the FLA, an employer may only require an employee to exhaust paid leave during family leave if this policy already exists for other leaves of absence. See N.J.A.C. 13:14-1.7. The Federal FMLA regulations differ in that use of paid leave for some or all FMLA leave is an option of the employee or may be required of the employee by the employer. See 29 CFR 825.207. Because of this difference between the FLA and FMLA, the Board believes that the Appendix should include a technical change, not requiring additional public notice and comment, to reflect this difference.

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

4A:6-1.1 General provisions

(a) In local service, appointing authorities shall establish types of leaves and procedures for leaves of absence.

1. Pursuant to this subchapter, employees in local service shall also be entitled to vacation leave (N.J.A.C. 4A:6-1.2(b) through (h)); sick leave (N.J.A.C. 4A:6-1.3(a) through (h)); military leave (N.J.A.C. 4A:6-1.11); gubernatorial appointment leave (N.J.A.C. 4A:6-1.12); convention leave (N.J.A.C. 4A:6-1.13); elective office leave (N.J.A.C. 4A:6-1.17); family leave under State law (N.J.A.C. 4A:6-1.21A); and Federal family and medical leave (N.J.A.C. 4A:6-1.21B).

2.-4. (No change.)

(b)-(e) (No change.)

4A:6-1.3 Sick leave

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

(g) Sick leave may be used by employees who are unable to work because of:

1. Personal illness or injury (see N.J.A.C. 4A:6-21B for Federal family and medical leave);

2. Exposure to contagious disease (see N.J.A.C. 4A:6-1.21B for Federal family and medical leave);

3. Care, for a reasonable period of time, of a seriously ill member of the employee's immediate family (see N.J.A.C. 4A:1-1.3 for definition of immediate family, see N.J.A.C. 4A:6-1.21A for family leave under State law and see N.J.A.C. 4A:6-1.21B for Federal family and medical leave); or

4. (No change.)

(h-(i) (No change.)

4A:6-1.6 Sick Leave Injury (SLI) requirements: State service

(a) (No change.)

(b) An employee who is disabled due to a work-related injury or illness shall be granted a leave of absence with pay.

1.-3. (No change.)

4. An employee receiving SLI benefits may also be entitled to medical leave under Federal law. See N.J.A.C. 4A:6-1.21B.

(c)-(e) (No change.)

4A:6-1.8 Pregnancy-disability and child care leave: State service

(a) A State employee in the career, senior executive or unclassified service who requests leave with or without pay for reason of disability due to pregnancy shall be granted leave under the same terms and conditions as those applicable to such employees for sick leave or leave without pay. The appointing authority may request acceptable medical evidence that the employee is unable to perform her work because of disability due to pregnancy. For medical leave under Federal law, see N.J.A.C. 4A:6-1.21B.

1.-2. (No change.)

(b) Child care leave may be granted to State employees under the same terms and conditions as all other leaves without pay. See

N.J.A.C. 4A:6-1.10. For family leave under State law, see N.J.A.C. 4A:6-1.21A. For Federal family and medical leave, see N.J.A.C. 4A:6-1.21B.

4A:6-1.10 Leave without pay: State service

(a)-(d) (No change.)

(e) For family leave under State law, see N.J.A.C. 4A:6-1.21A. For Federal family and medical leave, see N.J.A.C. 4A:6-1.21B.

4A:6-1.21 Family leave

(a) The following two sections include informational provisions on two leave programs: family leave ***(FLA)*** under State law (N.J.A.C. 4A:6-1.21A), and family and medical leave ***(FMLA)*** under Federal law (N.J.A.C. 4A:6-1.21B). It is the responsibility of every appointing authority to determine the extent to which one or both leave programs are applicable to the situation of an employee requesting leave, or whether neither program is applicable. If one or both programs are applicable, it is also the responsibility of the appointing authority to record the leaves appropriately and implement the applicable law(s).

(b) Following are examples of the interaction of the FMLA and FLA:

EXAMPLE ONE: A State employee needs to take leave for the birth of a child in 1994 and the birth of another child in 1995. If the employee is eligible for leave under both State and Federal laws, the employee may utilize the 12-week entitlement in 1994, which counts against leave under both laws. The State must comply with applicable provisions of both laws. More generous provisions of the FMLA, such as those on intermittent and reduced leave, apply. *[However, more generous provisions under State law, such as the retention of seniority, also apply.]*

In 1995, the employee is not entitled to family leave under State law because State law only permits 12 weeks of family leave in a two-year period. However, the employee is entitled to family leave under Federal law because the FMLA permits a family leave of 12 weeks in a 12-month period.

Leave during 1994 is recorded as both FLA and FMLA. Leave during 1995 is recorded as FMLA only.

EXAMPLE TWO: A municipal employee suffers from a serious health condition which makes the employee unable to perform his job duties. If the employee meets the criteria for eligibility under the FMLA, the employee is therefore entitled to 12 weeks of medical leave. This leave does not count against the employee's entitlement under State law because State law does not provide for leave for an employee's own serious health condition. Therefore, during the same 12-month period, if the employee needs to take leave because of the serious health condition of a child, the employee is entitled to 12 weeks of such leave under State law as long as the employee meets the criteria for eligibility.

EXAMPLE THREE: A State employee is disabled due to her pregnancy and is unable to work. The employee needs to take 12 weeks of leave for this reason. If the employee is eligible for medical leave under the FMLA, then the 12 weeks of pregnancy-disability leave will count toward her FMLA entitlement for that 12-month period. If she thereafter wishes to take 12 weeks of leave to care for her new child and is eligible for family leave under State law, she may then take 12 weeks of family leave. However, if the employee needs additional leave for child care, she may apply for leave without pay for this additional leave. The appointing authority may, but is not required to, grant such additional leave, since the employee has exhausted her leave entitlements under both State and Federal law. See N.J.A.C. 4A:6-1.10.

EXAMPLE FOUR: Joe is employed by the State Department of Insurance. His wife Jill is employed by the Department of State. Joe takes three weeks of leave to care for his seriously ill mother. Jill takes three weeks of leave to care for her newborn child. These three weeks are recorded on both of their records as State family leave (FLA) and Federal family leave (FMLA). They have remaining a combined total of six weeks of FMLA leave if used to care for their newborn child. However, if either is unable to work due to a serious health condition, each has nine weeks of FMLA leave remaining for that purpose. Each has nine weeks of FLA remaining.

EXAMPLE FIVE: An employee gives birth to a child on January 1. On November 1, she commences leave to care for her child, and completes this leave 12 weeks later. Her leave through December 31 is recorded as both FLA and FMLA. After December 31, the leave is recorded only as FLA.

EXAMPLE SIX: An employee takes in a foster child on December 1. He wishes to take a leave to care for the child commencing the following November 1. This leave is recorded as FMLA only, and only lasts through the end of November.

EXAMPLE SEVEN: An employee's wife gives birth on January 1. He commences leave on January 10. This leave is recorded as both FLA and FMLA, for a 12 week total.

EXAMPLE EIGHT: John is covered under a negotiations agreement. He has taken 12 weeks of leave, to end on December 31, 1993 because of his own serious health condition. Then he has a relapse and, on February 10, 1994, requires further leave. The leave does not fall under the FLA at all. Prior to February 5, 1994, the leave is also not recorded as FMLA. The leave commencing on February 10, 1994 is ***medical leave and is*** recorded as FMLA.

EXAMPLE NINE: Susan is a nonrepresented managerial employee who commences leave on July 1, 1993 for care of a newborn and needs leave for the next 15 weeks. From July 1 through August 4, the leave is recorded as FLA only. From August 5 through September 22 (12 weeks after July 1) the leave is recorded as FLA and FMLA. From September 23 through October 13, this leave is recorded as FMLA only.

EXAMPLE TEN: Robert is taking six weeks of paid sick leave for major surgery and recuperation from the surgery. Robert has informed his employer about the reason for his leave. His employer has designated this paid sick leave as FMLA leave. Immediately upon doing so, the employer also notifies Robert of this designation.

4A:6-1.21A State family leave

(a)-(j) (No change.)

4A:6-1.21B Federal family and medical leave

(a) The Federal Family and Medical Leave Act (FMLA), 29 U.S.C. 2601 et seq., was effective on August 5, 1993, except for employees covered under a collective negotiations agreement, for whom the Act is effective on February 5, 1994, or the date the agreement expires, whichever is sooner. This section is for informational purposes only, and addresses areas in which FMLA provisions differ from those under the State Family Leave Act (FLA). See N.J.A.C. 4A:6-1.21A. The U.S. Department of Labor has promulgated rules to implement and enforce the FMLA. See 29 CFR 825.

(b) Definitions, unique to this section, are as follows:

1. "Eligible employee" means an employee of the State or a political subdivision who has worked for the employer for at least 12 months for a minimum of 1,250 hours. In determining whether an employee meets this hours of service requirement, work not requested by an employer but suffered or permitted is work time for purposes of meeting this requirement. See 29 U.S.C. 207; 29 CFR 785.11.

2. "Family leave" means a type of FMLA leave to which an eligible employee is entitled if the employee meets the conditions set forth in (d)1 or (d)2 below.

3. "Medical leave" means a type of FMLA leave to which an employee is entitled if the employee meets the conditions set forth in (d)3 below.

4. "Parent" means a biological parent or an individual who stands or stood in loco parentis to an employee when the employee was a child. This term does not include parents "in law."

5. "Serious health condition" is an illness, injury, impairment, or physical or mental condition that involves:

i. Any period of incapacity or treatment in connection with or resulting from inpatient care in a hospital, hospice, or residential medical care facility;

ii. Any period of incapacity requiring absence from work, school, or other regular daily activities, of more than three calendar days, that also involves continuing treatment by a health care provider; or

iii. Continuing treatment by a health care provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days; or for prenatal care.

(c) Public agencies, including the State of New Jersey and political subdivisions, are covered employers without regard to the number of employees employed.

(d) An eligible employee of a covered employer is entitled to 12 weeks of FMLA leave in a 12-month period:

1. Because of the birth of a child or the placement of a child for adoption or foster care, except that the entitlement expires at the end of the 12-month period beginning on the date of birth or placement;

2. Because the employee is needed to care for a child, spouse or parent with a serious health condition; or

3. Because the employee's own serious health condition makes the employee unable to do his or her job.

(e) In State service, the 12-month period begins on the first day of FMLA leave.

(f) Leave may be taken intermittently or on a reduced leave schedule when medically necessary in the case of an employee who has a serious health condition or in the case of a child, spouse or parent who has a serious health condition.

1. Intermittent leave may last for as little as one hour or for as long as several weeks. A reduced leave schedule reduces the employee's hours per workweek or workday. No limit may be placed on the size of an increment of such leave, except that an employer may limit leave increments to the shortest period of time that the employer's payroll system uses to account for use of leave.

2. An employee may take leave in this manner for the birth or placement of a child for adoption or foster care only if the employer agrees.

(g) Special conditions related to FMLA leave are as follows:

1. A husband and wife who both work for the same employer are permitted to take a combined total of 12 weeks of FMLA leave in a 12-month period for the birth or placement for adoption or foster care of a child or to care for a parent with a serious health condition. However, following the use of a portion of the 12-week leave entitlement for one of these purposes, the husband and wife will each be entitled to the difference between the leave taken individually by them and their 12-week entitlement if the additional leave is for a different FMLA purpose (such as their own serious health condition).

2. Employers shall keep FMLA records for no less than three years and shall make them available for inspection, copying and transcription by representatives of the U.S. Department of Labor upon request. These records shall include all of the following:

i. Basic payroll and identifying employee data;

ii. Dates FMLA leave is taken by employees. FMLA leave shall be designated as such in the employer's records and shall not be placed in the same category as other leaves. A general designation, such as "sick leave," does not fulfill this requirement;

iii. The hours of the FMLA leave, if the leave is taken in increments of less than one full day;

iv. Copies of employee notices of leave which fall under the FMLA;

v. Copies of all general and specific notices given to employees as required under the FMLA and 29 CFR 825.300 et seq.;

vi. Any written or electronic documents describing employee benefits or employer leave policies outside of leave provisions found in N.J.A.C. 4A:6 et seq.;

vii. Premium payments of employee benefits; and

viii. Records of any dispute between the employer and an employee regarding designation of leave as FMLA leave, including any written statement from the employer or employee of the reasons for the designation and for the disagreement.

3. If the employer has a uniformly applied policy governing outside employment, such a policy may continue to apply to an employee while on FMLA leave. Otherwise, an employer may not deny benefits to an employee who is entitled to leave because the employee has outside employment.

4. The enforcing agency for FMLA leave is the Wage and Hour Division, Employment Standards Administration, U.S. Department of Labor. Any complaints related to this leave shall be made to that agency. Standardized forms are available from that agency for use by employers.

(h) If an employee qualifies under both Federal and State law, the leave used counts against the leave's entitlement under both laws, provided that nothing in the FMLA supersedes any provision of State law that provides greater rights than those provided under the FMLA, and further provided that rights under the FMLA shall not be diminished by State law.

(i) An employer may designate an employee's paid leave as FMLA leave if the employee provides information to the employer indicating an entitlement to such leave. The employer shall immediately notify the employee that the paid leave has been designated as FMLA leave.

(j) In State service, FMLA leave without pay shall not be deducted from seniority for layoff purposes. For all other purposes, FMLA leave without pay shall be treated the same as other leaves without pay.

4A:8-2.4 Seniority

(a)-(b) (No change.)

(c) The following types of leaves shall not be deducted from seniority calculations: all leaves with pay including sick leave injury (SLI); military, educational, gubernatorial appointment, personal sick, disability, and voluntary alternative to layoff leave without pay; family leave without pay under State law and, in State service, family and medical leave without pay under Federal law; and in local service, leave to fill elective public office. Suspensions, other leaves of absence without pay and any period an employee is laid off shall be deducted in calculating seniority.

(d)-(g) (No change.)

APPENDIX

Major Provisions of Federal and State Family and Medical Leave Laws

	Federal	New Jersey	
Issues	Enforced by U.S. Dept. of Labor	Enforced by Division on Civil Rights, Dept. of Law and Public Safety	Most Favorable to Employees
Employers Covered	Employers of 50 or more employees in at least 20 weeks of the current or preceding year	Similar	Comparable
Employees Eligible	Have worked for employer at least 1,250 hours in preceding 12 months and employed for at least 12 months; and employed at worksite by employer with 50 or more employees within 75 miles of that worksite	Have worked for employer at least 1,000 hours in preceding 12 months and employed for at least 12 months	New Jersey

Amount of Leave	12 weeks during a 12-month period Leave for birth, adoption, or to care for sick parent must be shared by spouses working for same employer	12 weeks during a 24-month period No reduction in leave requirement for spouses working for same employer	Federal, except for leave sharing requirement for spouses
Type of Leave	Birth, adoption or foster care; to care for parent, child or spouse with serious health condition, or employee's own serious health condition	Birth or adoption, serious health condition of parent, parent of spouse, child or spouse.	Federal for coverage of employee's own serious health condition New Jersey for coverage of in-laws
Serious Health Condition	Means illness, injury, impairment, or physical or mental condition involving incapacity or treatment connected with inpatient care in hospital, hospice, or residential medical-care facility; or, continuing treatment by a health care provider involving: (1) incapacity or absence of more than 3 days from work, school or other activities; (2) chronic or long-term condition incurable or so serious if not treated would result in incapacity of more than 3 days; or (3) prenatal care.	Means illness, injury, impairment, or physical or mental condition which requires inpatient care in a hospital, hospice or residential medical treatment or continuing supervision by a health care provider	Comparable
Health Care Provider	Means doctors of medicine or osteopathy authorized to practice medicine or surgery in the State; podiatrists, dentists, clinical psychologists, optometrists, chiropractors (for manual manipulation of spine to correct subluxation demonstrated by X-ray), nurse practitioners, and nurse-midwives, if authorized to practice under State law; or, Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts	Means any person licensed under Federal, State or local law, or the laws of a foreign nation, to provide health services, or any other person who has been authorized to provide health care by a licensed health care provider	Federal
Intermittent Leave	Permitted for serious health condition when medically necessary. Not permitted for birth or adoption unless employer agrees	Not permitted unless employer and employee agree	Federal in cases of serious health condition
Substitution of Paid Leave	Employee may elect or employer may require accrued paid leave to be substituted in some cases. No limits on substituting paid vacation or personal leave. Employee may not substitute paid sick, medical, or family leave for any situation not covered by employer's leave plan.	Similar***, but an employer may only require an employee to exhaust paid leave while on family leave if this policy is already in place for other, unpaid leaves of absence.***	*[Comparable]* ***New Jersey***
Reinstatement Rights	Must be restored to same or equivalent position in all terms and conditions	Similar	Comparable
Key Employee Exception	Exempts salaried employees if among highest paid 10 percent and if restoration would cause grievous economic harm to employer	Exempts highest paid five percent of employees or one of the seven highest paid employees, whichever is greater, if restoration would lead to substantial economic injury to employer.	New Jersey in most cases

Maintenance or Health Benefits During Leave	Health insurance must be continued under same conditions as prior to leave	Similar provision in New Jersey has been held to be preempted by ERISA in an April 1, 1991 Superior Court of New Jersey ruling.	Federal
Leave Requests	Made by employee 30 days in advance or as soon as practicable	Made by employee 30 days in advance or as soon as practicable for birth or adoption, 15 days in advance or as soon as practicable for serious health condition.	Comparable for birth or adoption New Jersey for serious health condition
Medical Certification May Be Required By Employer To Support:	Request for leave because of serious health condition	Similar for serious health condition of family member. Certification may also be required for the birth or placement of a child.	Federal
	Employee's fitness to return to work from medical leave	Not applicable, law does not provide leave for employee's own serious health condition.	Not Applicable
Executive, Administrative and Professional Employees	Salaried executive, administrative, and professional employees of covered employers who meet the Fair Labor Standards Act (FLSA) criteria for exemption from minimum wage and overtime under Regulations, 29 CFR Part 541, do not lose their FLSA-exempt status by using any unpaid FMLA leave. This special exception to the "salary basis" requirements for FLSA's exemption extends only to "eligible" employees' use of leave required by FLMA.	Unpaid leave would not result in loss of exempt status under State minimum wage and overtime law	Comparable

COMMUNITY AFFAIRS

(a)

BUREAU OF TECHNICAL SERVICES

Notice of Administrative Changes
Uniform Construction Code
Municipal Enforcing Agencies—Establishment
N.J.A.C. 5:23-4.3

Take notice that the Department of Community Affairs has discovered the need for two administrative changes to the text of N.J.A.C. 5:23-4.3(d). The paragraph (d)5 reference to "section 8 of this subchapter" (that is, N.J.A.C. 5:23-4.8) needs to be changed to refer to N.J.A.C. 5:23-4.17, to which N.J.A.C. 5:23-4.8 was recodified effective November 15, 1982. Paragraph (d)6 concerning the establishment of fire zones required by "section 16 of this subchapter" (that is, N.J.A.C. 5:23-4.16) needs to be deleted as obsolete, since N.J.A.C. 5:23-4.16 was repealed effective September 21, 1987. This notice of administrative changes is published pursuant to N.J.A.C. 1:30-2.7.

Full text of the changed rule follows (addition indicated in boldface **thus**; deletions indicated in brackets [thus]):

5:23-4.3 Municipal enforcing agencies—establishment

(a)-(c) (No change.)

(d) Established by ordinance:

1.-4. (No change.)

5. Such ordinance shall establish a system of fees in accordance with [section 8 of this subchapter] **N.J.A.C. 5:23-4.17**.

[6. Such ordinance or any subsequent amendment thereto, or any separate ordinance, shall when required by section 16 of this subchapter, establish fire zones.]

[7.]**6.** (No change in text.)

(e)-(g) (No change.)

(b)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code
Radon Hazard Subcode
Adopted Amendments: N.J.A.C. 5:23-10.1, 10.3 and 10.4

Proposed: July 5, 1994 at 26 N.J.R. 2704(a).

Adopted: November 10, 1994 by Harriet Derman, Commissioner, Department of Community Affairs.

Filed: November 15, 1994 as R.1994 d.609, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 52:27D-124.

Effective Date: December 19, 1994.

Operative Date: April 1, 1995.

Expiration Date: February 3, 1998.

Summary of Public Comments and Agency Responses:

Comments were received from the following individuals and organizations: Andy Cattano, Director Technical Services of the New Jersey Builders Association; Martin M. Bloomenthal, Director of Technical Quality Assurance of the Hillier Group; and Tom Hatton and John Valdata, President and Vice President, respectively, of Garden State Chapter of the American Association of Radon Scientists and Technologists (GSAARST).

COMMENT: The Department should eliminate the plumbing subcode official from having any radon hazard subcode enforcement responsibility and should reassign these areas of enforcement to the building subcode official.

COMMENT: The Department should eliminate the fire protection subcode official from radon hazard subcode enforcement responsibility

under N.J.A.C. 5:23-10.3(b)1iii and v and should reassign these enforcement areas to the building subcode official.

RESPONSE: The Department has considered both of these comments and has determined that enforcement of the radon hazard subcode, as such, is properly the responsibility of the building subcode official. The other subcode officials are involved only to the extent that work that would ordinarily fall within the jurisdiction of their respective subcodes is done as part of the radon-related work. It is therefore inaccurate to refer to them as having duties specific to the radon hazard abatement subcode. The rules are being corrected at this time at N.J.A.C. 5:23-10.3(b) in order to make that clear.

COMMENT: The rules appear to prohibit the use of a perforated piping network for slab-on-grade construction. The use of a perforated piping network system should be permissible.

RESPONSE: Although the construction techniques contained in the radon hazard subcode do not specifically mention the use of a perforated pipe network system in lieu of "T" pipe fittings, the Department's position is that a perforated pipe network system for slab on grade construction is an equivalent or more extensive construction technique which is not prohibited pursuant to N.J.A.C. 5:23-10.4(b). The Department is not aware of any installation not being approved for utilizing a perforated pipe network system in lieu of "T" pipe fittings. Therefore, no change to this section is being made.

COMMENT: The regulations should be expanded to include provisions assuring the "T" fittings are properly anchored, secured, and remain open.

RESPONSE: The Department feels that the current "T" pipe fitting requirement have been adequate in keeping the piping plumb and in providing adequate opening. In addition, the change in the rule to require that the "T" pipe fitting be connected to an independent pipe should provide an even more stable installation. Therefore, the Department feels that expanding the requirements is not necessary at this time. In any event, significant additions cannot be made to a rule proposal at the time of adoption.

COMMENT: The regulations should include a provision to require a continuous gravity pitch for water drainage.

RESPONSE: The Department agrees that the vent pipe should be installed with proper pitch for water drainage. In order to clarify this, the Department has added a statement at N.J.A.C. 5:23-10.4(b)12 that the vent pipe shall be installed in a configuration and supported in a manner that ensures that water or condensate accumulation within the pipes drains downward into the ground beneath the slab or vapor barrier.

COMMENT: Several "preferential" construction provisions are recommended by the commenter to be included in the regulations.

RESPONSE: As is stated in N.J.A.C. 5:23-1.3(a)4, one purpose of the State Uniform Construction Code was to eliminate preferential treatment to types or classes of material or products or methods of construction. Since the suggested "preferential" provisions would not be in agreement with this stated intent, this recommendation cannot be adopted. In the Department's view, the actual specific design is best left up to the design professional.

COMMENT: The rules should make it clear that multiple vent pipes may be interconnected into one vent pipe stack.

RESPONSE: The rules do not prohibit interconnection of vent pipe sections into one independent stack rack. In order to address the commenter's concerns regarding this matter, the Department is providing clarification at N.J.A.C. 5:23-10.4(b)4 by making this explicit.

COMMENT: References to the plumbing subcode are unnecessary and should be deleted since radon abatement installations are not plumbing systems.

RESPONSE: The Department agrees that radon abatement installations are not plumbing systems and, as indicated in the proposal, has deleted reference to the plumbing subcode.

COMMENT: Several commenters requested that the regulations should include provisions that require or would provide sufficient clearances in anticipation of an in-line vent pipe fan installation.

RESPONSE: It was implicit in the proposal that the piping be capable of having an in-line vent pipe fan installed. In order to clarify this, the Department has revised the text at N.J.A.C. 5:23-10.4(b)12 to state that the vent pipe shall be routed in a way that makes it accessible in a non-conditioned space for installation of a future in-line vent pipe fan.

COMMENT: The commenter supports the vent pipe termination requirement of "12 inches above the roof" for new construction and recommends that ground level exhausts be permitted similar to direct-vent furnaces and water heaters.

RESPONSE: The requirement in N.J.A.C. 5:23-10.4(b)12i, which specifies for vent pipe termination 12 inches above the roof, is not applicable to existing structures, as is stated in N.J.A.C. 5:23-10.1(c)4. Although the commenter supports this provision for new construction, the Department has recognized the impracticality of attempting to apply this provision to high-rise buildings and certain other structures and therefore is requiring at N.J.A.C. 5:23-10.4(b)12i termination above the roof only for buildings three stories or less, while otherwise allowing the sidewall vent termination option, provided the vent is at least 20 feet above grade and effectively screened.

COMMENT: N.J.A.C. 5:23-10.4(b)12i should be revised to prohibit roof vent termination when the vent adjoins a sleeping area because of the noise likely to be created by the future installation of a constant running in-line vent pipe fan.

RESPONSE: Since there is no requirement for an in-line vent pipe fan to be installed, the impact(s) of installing a future in-line vent pipe fan are, in the Department's view, design considerations best left to the design professional.

COMMENT: It is recommended that N.J.A.C. 5:23-10.4(b)12ii be modified so as to exclude attics, garages and other areas that are not living space from radon vent pipe terminal set-back requirements.

RESPONSE: The Department feels that the requirement that no vent terminal shall be located directly beneath any door, window, or other ventilating opening of the building is not an unreasonable burden for new construction. When building a house, there is no need to allow possible radon concentration even in those areas of a building that are not considered living space.

COMMENT: Several commenters felt the requirement for radon vent pipe termination at a lateral distance of 10 feet may be too difficult to meet and suggested an eight foot distance.

RESPONSE: The Department has reviewed this section and recognizes that the 10 foot horizontal distance may not be possible in some cases, such as those in which there is lot widths of 20 feet or less. Therefore, the Department is adding the statement at N.J.A.C. 5:23-10.4(b)12iii that where this 10 foot horizontal distance is not possible due to lot width, the vent terminal shall be placed so as to be as remote from the lot line as practicable.

COMMENT: The requirement, in the proposed N.J.A.C. 5:23-10.4(b)14, concerning installation of receptacles and lighting in an area in which radon mitigation may be done in the future should be deleted. Electrical work should be left to the owner or radon mitigator at the time of fan installation.

COMMENT: Installation of receptacles is appropriate, but lighting is not necessary.

RESPONSE: In response to these comments, the Department has reviewed the text in N.J.A.C. 5:23-10.4(b)14 and has changed the requirement so that it will be the same as that set forth in the Federal EPA's "Model Standards and Techniques." The EPA text provides that "electrical junction boxes shall be installed during construction in proximity to the anticipated locations of vent pipe fans and system failure alarms." The Department accepts the Federal determination that a junction box is sufficient and that neither receptacles nor lighting should have to be installed at the time of construction.

COMMENT: The reference to "additions" in N.J.A.C. 5:23-10.3(b)1 should be deleted since the enabling legislation references the construction of **new** schools and residential buildings throughout.

RESPONSE: N.J.S.A. 5:27D-123a provides that the purpose of the radon hazard subcode is to ensure that schools and residential buildings within tier one areas are constructed in a manner that minimizes radon gas and radon progeny entry and facilitates any subsequent remediation that might prove necessary. "Construction" includes additions to existing buildings as well as new buildings.

COMMENT: What is the definition of an "addition" and does this include add-a-level additions?

RESPONSE: The term "addition" is defined in the BOCA National Building Code, as "an increase in building area, aggregate floor area, height or number of stories of a structure." This is consistent with commonly-accepted usage and would include an add-a-level addition. Additions above the ground floor, however, are not required to comply with the radon hazard subcode because they are not in contact with the ground.

COMMENT: Who is expected to perform radon protection construction techniques for additions to existing buildings?

RESPONSE: The radon hazard subcode does not specify "who" must perform the installation of the required radon hazard protective features.

The jurisdiction of the Department under the State Uniform Construction Code Act does not include the regulation or licensing of any trade or profession engaged in construction work.

COMMENT: New home builders are required to warrant work pursuant to the New Home Warranty and Builder's Registration Act. How would radon protection work be warranted in additions?

RESPONSE: Changes, alterations, or additions made to a home by anyone after initial occupancy, except those performed by the builder as his or her obligation under the new home warranty, are not covered by the warranty. Radon hazard protection in additions is therefore not covered.

COMMENT: To apply the radon hazard subcode to additions, irrespective of size and relationship to the existing building, would be unreasonable.

RESPONSE: The intent of the proposed amendments was not to require complete compliance with the Radon Hazard Subcode construction techniques for all additions and renovations. It was the intent of the amendments to require additions and renovations to comply only with the portions of the radon hazard subcode construction techniques for which compliance would be feasible. The Department has clarified this in N.J.A.C. 5:23-10.4(b).

COMMENT: The connection of sub-slab pipework or "T" fitting stubouts to the independent vent stack as proposed at N.J.A.C. 5:23-10.4(b)3-4 will provide for a functional passive radon prevention system and will facilitate activation of the system, if necessary. While additional costs will be incurred, this part of the proposal makes good sense.

RESPONSE: The Department agrees with this comment.

COMMENT: It is suggested that N.J.A.C. 5:23-10.1(c)3 be expanded to reinforce language in N.J.A.C. 5:23-10.4(b) to the effect that the construction techniques are minimum provisions and that builders of Use Group R and E buildings may exceed said provisions to whatever extent they so choose prior to the transfer of title or issuance of a certificate of occupancy.

RESPONSE: The Department considers the existing text to be sufficiently clear. Code requirements are "minimum/maximum" in that officials may require neither more nor less than the code provides. Builders and owners are always at liberty to build in greater protection than is required.

COMMENT: The phrase "gas tight" in N.J.A.C. 5:23-10.4(b)12 should be defined. Without a definition, construction code officials may request verification of gas tightness by testing.

RESPONSE: The Department does not feel that the phrase needs to be further defined. No requirement for testing for gas tightness is currently contained within the Radon Hazard Subcode. The Department feels that the non-inclusion of a gas tightness test is sufficient at this time.

COMMENT: The language at N.J.A.C. 5:23-10.4(b)2i, second sentence, is somewhat confusing and needs clarification of the intent.

RESPONSE: The Department agrees that the language, which was taken from the vent terminal extension above roofs section of the plumbing subcode, is somewhat confusing. The Department has amended the text to clarify the intent.

COMMENT: N.J.A.C. 5:23-10.4(b)15 needs clarification. Although buildings constructed over crawl spaces are not required to have vent pipes, the Department is referring to scenarios where basement areas are open to crawl space areas (with slabs), or slab-on-grade areas are open to crawl space areas (unusual), and each area be provided with a vent pipe system into the sub-slab aggregate or pipework, which is then interconnected at some point to form a single vertical stack.

RESPONSE: As stated, the Department is requiring, in combination basement/crawl space or slab-or-grade/crawl space buildings, that a vent pipe interconnect these areas. The Department feels that "during construction" is the most appropriate time to install this piping network, which may be needed for radon mitigation.

COMMENT: N.J.A.C. 5:23-10.4(b)16 is not necessary. The integrity of the thermal envelope, in this instance top-flooring ceilings, is generally assured pursuant to the energy subcode.

RESPONSE: The Department disagrees with the comment that N.J.A.C. 5:23-10.4(b)16 is not necessary. The Department agrees that provisions within the energy subcode generally require barriers which reduce stack effect; however, this radon hazard subcode provision addresses the cases that may not be addressed by the energy subcode.

COMMENT: The Department should adopt graphics depicting the radon hazard subcode construction techniques.

RESPONSE: The Department will consider issuance of a bulletin containing this information.

COMMENT: The NJBA takes issue with the Department's economic impact statement, which states that the cost of compliance with the rules as proposed would be in the range of $50.00 to $300.00, depending on the type of building. Material and labor costs for certain items may cost builders or owners hundreds of dollars more.

RESPONSE: The Department agrees that costs may be higher in some cases. The economic impact statement, however, emphasized that the cost of incorporating radon hazard construction techniques during construction would be considerably less expensive than correcting a radon problem later. For example, a home built in compliance with the rules in effect prior to these amendments might not have the access to electric power for the system that will now be required. Providing this access during construction would have cost not more than $50.00, but it would be considerably more expensive if added later.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

5:23-10.1 Title, scope; intent

(a)-(b) (No change.)

(c) This subchapter seeks to protect and ensure public safety, health and welfare insofar as it is affected by radon entry into schools and residential buildings.

1.-3. (No change.)

4. The installation of radon mitigation systems in existing portions of buildings shall not be subject to the construction technique requirements set forth in N.J.A.C. 5:23-10.4.

5:23-10.3 Enforcement

(a) (No change.)

(b) Enforcement responsibility shall be divided among subcode officials in the following manner:

1. For new structures and additions:

i. *[Plan]* ***Except as otherwise indicated in (b)1ii below, plan*** review and inspection with regard to compliance with N.J.A.C 5:23-10.4(b)*[1, 2, 10 and 11]* shall be the responsibility of the building subcode official;

ii. *[Plan review and inspection with regard to compliance with N.J.A.C. 5:23-10.4(b)3, 4, 5, 7, 8 and 15 shall be the responsibility of the plumbing subcode official]* ***Plan review and inspection with regard to work performed under N.J.A.C. 5:23-10.4(b) that is otherwise subject to the plumbing, electrical or fire protection subcode shall be the responsibility of the plumbing, electrical or fire protection subcode official, respectively.****

*[iii. Plan review with regard to compliance with N.J.A.C. 5:23-10.4(b)6, 9 and 16 shall be the joint responsibility of the building and fire protection subcode officials;

iv. Inspection with regard to compliance with N.J.A.C. 5:23-10.4(b)6, 9 and 16 shall be the responsibility of the building subcode official;

v. Plan review with regard to compliance with N.J.A.C. 5:23-10.4(b)12 shall be the joint responsibility of the building, fire protection and plumbing subcode officials;

vi. Inspection with regard to compliance with N.J.A.C. 5:23-10.4(b) 12 and 13 shall be the responsibility of the plumbing subcode official; and

vii. Plan review and inspection with regard to compliance with N.J.A.C. 5:23-10.4(b)14 shall be the responsibilty of the electrical subcode official.]*

2. For existing structures:

i. Construction enforcement responsibility for verification that radon mitigation work in all structures, other than detached one and two family dwellings, is in conformance with the adopted subcodes shall be as set forth in N.J.A.C. 5:23-3.4(a), (c), (d) and (f).

ii. In existing detached one and two family dwellings, the building subcode official shall be responsible for verification that all construction aspects of radon mitigation work are in conformance with the adopted subcodes, except that the electrical subcode official shall be responsible for those construction aspects that are subject to the electrical subcode.

5:23-10.4 Construction techniques

(a) (No change.)

(b) The construction techniques set forth in this subsection shall be the minimum radon hazard protective features required to be incorporated into construction of buildings in Use Groups E and R in tier one areas, and may be incorporated elsewhere, in order to minimize radon and radon progeny entry and facilitate any post-construction radon removal that may be required. Enumeration of these construction techniques is not intended to preclude voluntary use of additional or more extensive techniques. ***Full compliance with these construction techniques is not required for additions; however, those construction techniques that are feasible shall be incorporated.***

1.-2. (No change.)

3. Basement slabs with interior foundation pipe drains installed shall have a solid three-inch minimum diameter vent pipe section installed in conjunction with this drainage system and be connected to an independent vent stack pipe terminating at an approved location on the exterior of the building.

4. Basement slabs which do not have an interior foundation pipe drain*,* and slab on grade construction (excluding non-habitable spaces such as garages)*,* shall be provided with one three-inch minimum solid vent pipe section with a "T" pipe fitting for every 1,500 square feet, or portion thereof, of slab area, this vent pipe section to be installed into the sub-slab aggregate. The horizontal openings of the "T" pipe fitting shall be placed in the sub-slab aggregate. The vertical portion of the "T" pipe fitting shall be connected to an independent vent stack pipe terminating at an approved location on the exterior of the building. ***Where more than one vent pipe section is provided, interconnection of these sections into a single independent vent stack is permitted.***

5.-11. (No change.)

12. The independent vent stack pipe provided in accordance with (b)3, 4 or 8 above shall be an adequately supported, gas tight, three-inch minimum diameter solid pipe, through any enclosed portions of the building*.**[, meeting]* ***The pipe shall be routed in a manner that makes it accessible for the installation of a future in-line vent pipe fan in a non-conditioned (not heated or cooled) space, including, without limitation, an attic space, but excluding a basement or crawl space, and installed in a configuration, and supported in a manner, that will ensure that rain water or condensate accumulation within the pipes will drain doward into the ground beneath the slab or vapor barrier. The vent stack pipe shall meet*** the following termination requirements:

i. Vent pipes shall terminate ***at least*** 12 inches above the roof, measured from the highest point where the vent intersects the roof. *[Where a roof is to be used for any purpose other than weather protection, the vent extension(s) shall run]* ***When a vent pipe extension terminates on an occupiable roof the vent pipe shall extend*** at least seven feet above the roof ***surface. Exception: Buildings more than three stories in height shall be allowed to extend vent pipe terminals through a wall provided that the termination is at least 20 feet above grade and is effectively screened*.**

ii. No vent terminal shall be located directly beneath any door, window, or other ventilating opening of the building or of an adjacent building nor shall any such vent terminal be within 10 feet horizontally of such an opening unless it is at least two feet above the top of such opening.

iii. No vent terminal shall be closer than 10 feet horizontally from any lot line. ***Where this 10 foot horizontal distance is not possible due to lot width, the vent terminal shall be placed as remote from the lot line as practicable.***

13. Radon vent pipes shall be identifiable and clearly labeled at intervals of not more than 25 feet in concealed locations, not more than 50 feet in exposed locations and not less than once in any room or space.

14. *[Lighting and at least one 125 volt, single phase, 15- or 20-ampere rated receptable]* ***Electrical junction boxes*** shall be installed near the provided area, such as an accessible attic space, where a future in-line vent pipe fan ***and system failure alarms*** may be installed.

15. In combination basement/crawl space or slab-on-grade/crawl space buildings a three-inch minimum solid vent pipe shall be provided between the areas and interconnected into the independent vent stack to permit use of a single in-line vent pipe fan if activation of the system is desired.

16. In order to reduce stack effect, air passages that penetrate the conditioned envelope of the building, such as attic access openings, or other openings installed in top-floor ceilings, shall be closed, gasketed or otherwise sealed with materials approved for such applications.

(a)

DIVISION OF HOUSING AND DEVELOPMENT

New Home Warranties and Builder Registration Denial of Registration

Adopted Amendment: N.J.A.C. 5:25-2.5

Proposed: May 16, 1994 at 26 N.J.R. 1913(a).
Adopted: November 10, 1994 by Harriet Derman, Commissioner, Department of Community Affairs.
Filed: November 15, 1994 as R.1994 d.610, **without change.**

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

Effective Date: December 19, 1994.
Expiration Date: February 19, 1996.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

5:25-2.5 Denial, suspension or revocation of registration

(a) (No change.)

(b) A certificate of registration may be denied or suspended, pending compliance with the Act, with this chapter and with the orders of the Commissioner, if the registrant or applicant, or an officer, partner, director, or stockholder of the registrant or applicant, has at any time:

1.-7. (No change.)

(c)-(e) (No change.)

EDUCATION

(b)

STATE BOARD OF EDUCATION

State-Operated Schools Districts

Readoption with Amendments: N.J.A.C. 6:7

Proposed: September 6, 1994 at 26 N.J.R. 3524(b).
Adopted: November 7, 1994 by State Board of Education, Leo Klagholz, Secretary, State Board of Education and Commissioner, Department of Education.
Filed: November 18, 1994 as R.1994 d.616, **without change.**

Authority: N.J.S.A. 18A:1-1, 18A:4-15 and 18A:7-45.

Effective Date: November 18, 1994, Readoption;
December 19, 1994, Amendments.
Expiration Date: November 18, 1999.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 6:7.

Full text of the adopted amendments follows:

6:7-1.2 Procedure for evaluation

(a) Within 30 days of appointment, the State district superintendent shall establish an assessment unit which shall conduct on-site

evaluations of each building principal in the State-operated school district.

(b) (No change.)

(c) Upon completion of each evaluation, the assessment unit shall provide a written evaluation report to the State district superintendent and the building principal.

6:7-2.2 Criteria for evaluation of building principals in State-operated school districts

(a) An evaluation shall include, but not be limited to, an examination of the principal's performance based on the following criteria within the identified areas of school building leadership/management established pursuant to N.J.S.A. 18A:7A-45a:

1.-5. (No change.)

6. School Climate: The principal exhibits consistent and effective leadership in creating a positive learning environment.

(b) (No change.)

ENVIRONMENTAL PROTECTION

(a)

DIVISION OF FISH, GAME AND WILDLIFE

Marine Fisheries

General Net Regulations

Adopted Amendments: N.J.A.C. 7:25-18.1 and 18.5

Proposed: May 16, 1994 at 26 N.J.R. 1931(a).

Adopted: November 16, 1994 by Robert C. Shinn, Jr., Commissioner, Department of Environmental Protection.

Filed: November 17, 1994 as R.1994 d.615, **with technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 23:2B-6.

DEP Docket Number: 24-94-04/320.

Effective Date: December 19, 1994.

Expiration Date: February 15, 1996.

The New Jersey Department of Environmental Protection is adopting the amendments to General Net Regulations N.J.A.C. 7:25-18.1 and 18.5 proposed on May 16, 1994 at 26 N.J.R. 1931(a). The comment period closed June 15, 1994.

Summary of Public Comments and Agency Responses:

No comments received.

Summary of Agency-Initiated Changes:

At N.J.A.C. 7:25-18.1(a), two scientific names require minor technical corrections. Under the heading Scientific Name, *Busycotypus carica* should be changed to *Busycon carica* and *Busycotypus contrarium* should be changed to *Busycon contrarium*. The Scientific Name, *Busycotypus canaliculatum*, is correctly written.

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

7:25-18.1 Size and possession limits

(a) A person shall not purchase, sell, offer for sale, or expose for sale any species listed below less than the minimum length, measured in inches. Fish length shall be measured from the tip of the snout to the tip of the tail.

Species	Scientific Name	Minimum Size (inches)
Atlantic Mackerel	*Scomber scombrus*	7
Black Sea Bass	*Centropristis striata*	8
Bluefish	*Pomatomus saltatrix*	9
Conch	*[*Busycotypus*]* ***Busycon*** *carica* *Busycotypus canaliculatum* *[*Busycotypus*]* ***Busycon*** *contrarium*	5
Kingfish	*Menticirrhus saxatilis* *Menticirrhus americanus*	8
Porgy (Scup)	*Stenotomus chrysops*	7
Goosefish (Monkfish)	*Lophius americanus*	17

In addition to the total minimum goosefish size, all goosefish tails possessed must be at least 11 inches in length from the anterior portion of the fourth cephalic dorsal spine to the end of the caudal fin. The total weight of all goosefish livers landed shall not be more than 30 percent of the total weight of all goosefish tails landed or 12 percent of the total weight of all goosefish landed.

(b)-(q) (No change.)

7:25-18.5 General net regulations

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

(g) Individuals intending to take fish with a net in the marine waters of this State pursuant to N.J.S.A. 23:5-24.2 shall, as required, apply to the Commissioner for a licensee and/or permit. To be eligible to purchase a 1992 license for a drifting, staked or anchored gill net the applicant shall have purchased a gill net license during 1990, 1991 or a 1992 license prior to May 1, 1992 or provide documented proof of active military service within one year of application. An applicant who does not meet the above requirements must file an application, in person, with the Department in each of two consecutive years. Such an applicant shall be eligible for gill net licenses in the following calendar year. Beginning in the license year (January 1-December 31) 1993, an applicant for a gill net license must have possessed a gill net license in one of the two previous years. Failure to purchase a gill net license in one of the two previous years shall subject the applicant to the two year waiting period described above. Availability of Delaware Bay Gill Net Permits shall be determined pursuant to N.J.A.C. 7:25-18.6 through 18.11. Upon receipt of the applications, and the prescribed license fee, the Commissioner may, in his or her discretion, issue single season licenses and/or permits as specified for each net type for the taking of fish with nets only as follows:

1.-10. (No change.)

11. Lobster or fish pots may be used for the taking of all species except those specifically protected and shall be used only in the Atlantic Ocean, Delaware Bay, Raritan Bay, and Sandy Hook Bay except as provided in (g)11vii below.

i.-vi. (No change.)

vii. A modified lobster or fish pot may be used for the taking of conchs or whelks in all marine waters of the State including the Atlantic Ocean with the exception of the Newark Bay Complex.

(1) Any such conch pot is defined as a rectangular shaped device not larger than 30 inches on any side; or a cylindrical shaped device not greater than 34 inches in diameter and 30 inches in height. Conch pots must allow for an unobstructed opening on their top surface measuring not less than eight by eight inches square or nine inches in diameter. Conch pots cannot contain a parlor, funnel, or other entrapping mechanism in the interior of the pot. Any similar configuration may be approved for use upon application to the Division and receipt of written approval. Such applications must contain a diagram detailing the shape and dimensions of the requested conch pot configuration.

(2) Conch pots may be tended only from 0400 hours (4:00 A.M.) to 2100 hours (9:00 P.M.).

(3) No conch pot shall be placed in a creek, ditch or tributary less than 50 feet wide at mean low water, in any marked or charted channel or in any man-made lagoon;

Recodify existing vii and viii as viii and ix (No change in text.)

12. (No change.)

(h) (No change.)

HIGHER EDUCATION

(a)

NEW JERSEY HIGHER EDUCATION ASSISTANCE AUTHORITY (NJHEAA)

Eligibility Criteria for NJCLASS Loans

Adopted Amendments: N.J.A.C. 9:9-7.1, 7.2 and 7.3

Proposed: August 15, 1994 at 26 N.J.R. 3242(a).
Adopted: November 18, 1994 by the New Jersey Higher Education Assistance Authority, Warren E. Smith, Chairman.
Filed: November 18, 1994 as R.1994 d.617, **with technical changes** not requiring additional public notice and comments (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 18A:72-10.

Effective Date: December 19, 1994.
Expiration Date: August 16, 1998.

Summary of Public Comments and Agency Responses:
The proposed amendment was published on August 15, 1994. During the comment period, which closed on September 14, 1994, one comment was submitted by Dr. Vera King Farris, the President of Stockton State College:

COMMENT: The proposal should clarify the meaning of "licensed by the State," and should refer to the Council on Postsecondary Accreditation by the name of its successor organization, "Commission on Recognition of Postsecondary Accreditation."

RESPONSE: The New Jersey Higher Education Assistance Authority clarifies that "licensed by the State" means "licensed by the New Jersey Commission on Higher Education." "Council on Postsecondary Education" is replaced by the name of its successor organization, "Commission on Recognition of Postsecondary Accreditation."

Summary of Agency Initiated Changes:
A typographical error of the word "improved" was corrected in N.J.A.C. 9:9-7.2(a)5.

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

9:9-7.1 Definitions

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

...

"Co-signer" means an individual who signs a promissory note and agrees to repay the loan in the event the borrower does not.

"Eligible collegiate institution" or "school" or "college" means a college or university approved or licensed by the *[State]* ***New Jersey Commission on Higher Education*** or accredited by a regional accrediting association recognized by the *[Council on Postsecondary Accreditation]* ***Commission on Recognition of Postsecondary Accreditation*** and having a New Jersey cohort default rate of 20 percent or less.

...

"Parent borrower" means a parent(s), spouse, legal guardian or other relative of a dependent undergraduate or graduate student.

...

"Reaffirmation" means the acknowledgment of the loan by the borrower or co-signer in a legally binding manner.

...

(b) (No change.)

9:9-7.2 Eligibility

(a) To be eligible for a NJCLASS loan, each applicant must:

1. Be a citizen, national or legal resident of the United States or be in the U.S. for other than temporary purposes and intend to become a permanent resident (as evidenced by Immigration and Naturalization Service documentation);

2. Be a permanent resident of New Jersey for at least six months prior to filing a NJCLASS application;

3. Not be in default on any student loan or in violation of any of the other criteria for determining creditworthiness as set forth in the NJCLASS application;

4. Provide an acceptable co-signer if it is determined by the Authority that one is required; and

5. Reaffirm any Federal Family Education Loan amount or any NJCLASS loan amount that previously was cancelled due to the applicant's total and permanent disability and obtain a certification from a physician that the applicant's condition has improved and that the applicant is able to engage in substantial gainful activity. If the applicant is not the student, the student on whose behalf another borrower is applying for a NJCLASS loan must reaffirm any Federal Family Education Loan amount or any NJCLASS loan amount that previously was cancelled due to the student's total and permanent disability and obtain a certification from a physician that the student's condition has *[inproved]* ***improved*** and that the student is able to engage in substantial gainful activity.

(b) In addition to all of the requirements in (a) above, a student applicant or a student on whose behalf the parent and/or borrower is applying for a NJCLASS loan shall:

1. Be a citizen, national or legal resident of the United States or be in the U.S. for other than temporary purposes and intend to become a permanent resident (as evidenced by Immigration and Naturalization Service documentation);

2. Have a high school diploma or a high school equivalency certificate;

3. Be enrolled or accepted for enrollment on at least a part-time basis in an eligible school;

4. If currently enrolled in an eligible school, be determined by the school to be making satisfactory academic progress; and

5. Have exhausted eligibility for or be ineligible for Federal Family Education Loans, and other forms of student assistance, excluding PLUS loans or student assistance under subpart I or part C of title VII of the Public Health Service Act.

9:9-7.3 Loan amounts

(a) The amount borrowed shall not exceed a student's estimated cost of attendance at the eligible school minus all other financial assistance for which the student is eligible (excluding PLUS loans or student assistance under subpart I or part C of title VII of the Public Health Service Act) for the academic period for which the loan is intended.

(b) The minimum amount which may be borrowed is $500.00.

HUMAN SERVICES

(b)

DIVISION OF FAMILY DEVELOPMENT

Child Care Services Manual

Readoption with Amendments: N.J.A.C. 10:15, 10:15A, 10:15B and 10:15C

Proposed: August 15, 1994 at 26 N.J.R. 3327(a).
Adopted: November 23, 1994 by William Waldman, Commissioner, Department of Human Services.
Filed: November 23, 1994 as R.1994 d.628, **with substantive and technical changes** not requiring additional public notice and comment. (See N.J.A.C. 1:30-4.3.)

Authority: N.J.S.A. 30:1-12; 45 CFR. Parts 98 and 257; and the Americans with Disabilities Act (P.L. 101-336).

Effective Date: November 23, 1994, Readoptions; December 19, 1994, Amendments.
Expiration Date: November 23, 1999.

Summary of Public Comments and Agency Responses:
No comments were received.

Summary of Agency-Initiated Changes:

As a result of an internal review, the following changes have been made:

The definition of "approved homes" at N.J.A.C. 10:15-1.2 and 10:15A-1.3(d)2 has been revised so as not to conflict with existing requirements at N.J.S.A. 30:5B-1 through 15 for registered family day care providers and licensed child care center arrangements. The existing requirements impose a limit of five children who are permitted to be present in a provider arrangement without requiring the issuance of a license and/or certificate. This limit is imposed regardless of sibling status of the children.

To avoid confusion in terminology, the term "licensed child care center," which is used in the Manual of Requirements for Child Care Centers (N.J.A.C. 10:122), replaces the term "licensed center-based care".

At N.J.A.C. 10:15A-1.3(b), an incorrect citation has been corrected. Additionally, for clarification purposes, N.J.A.C. 10:15A-1.3(b)1 has been amended to distinguish between child care centers which may be legitimately exempt from licensing and those which may be excluded from the definition of a child care center without having an actual letter of exemption from the DYFS Bureau of Licensing.

For clarification purposes, N.J.A.C. 10:15A-1.3(b)3 has been amended by clarifying that summer camps are to be approved by the New Jersey Department of Health pursuant to N.J.S.A. 26:12-1 et seq., as well as N.J.A.C. 8:25.

N.J.A.C. 10:15B-1.2(h) and 2.2(h) have been amended so as not to imply that the conditions contained in these provisions must be met by all families as a requirement for eligibility in the ARCC or CCDBG programs.

The following technical corrections have been made to improve grammar, punctuation and clarity.

N.J.A.C. 10:15-2.1(k)4, deleted the final "and".

N.J.A.C. 10:15-2.1(k)5, deleted the final period; and added a semi-colon and "and".

N.J.A.C. 10:15-2.2(b)3, deleted the final period; and added a semi-colon and "and."

N.J.A.C. 10:15-2.3(a)19, deleted the final period; and added a semi-colon.

N.J.A.C. 10:15-2.5(a)7, deleted the final period; added a semi-colon and "and"; and changed "for which they are eligible" to "for which the parent/applicant is eligible."

N.J.A.C. 10:15A-1.1(e), deleted the semi-colon before "informs the family"; added a semi-colon after "through these child care programs"; changed "their need for child care referral services" to "the parent/applicant's need for child care referral services"; and changed "informs the family that they are eligible for services" to "informs the parent/applicant that he or she is eligible for services."

N.J.A.C. 10:15A-1.2(b), changed "unless the parent/applicant requires full time care year round due to their work schedule" to "unless the parent/applicant requires full time care during these periods due to his or her work schedule."

N.J.A.C. 10:15A-1.2(g), changed "ends or no longer attends their training/education activity" to "ends or no longer attends his or her training/education activity."

N.J.A.C. 10:15A-1.5(a)1i, changed "treatment of plan of the child" to "treatment plan for the child."

N.J.A.C. 10:15B-1.1(b), changed "resides in their own home with their parents" to "resides in his or her own home with his or her parent(s)."

N.J.A.C. 10:15B-2.1(c), changed semi-colon to comma before "including foster care."

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 10:15, 10:15A, 10:15B and 10:15C.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

10:15-1.1 Purpose and scope

(a) (No change.)

(b) The child care service programs, described herein, were made available originally through block grant monies of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Public Law 101-508. The block grant child care service programs are: The Aid to Families with Dependent Children (AFDC) At-Risk Child Care (ARCC) Program as implemented originally by Section 5081 of OBRA 1990; and the Child Care and Development Block Grant (CCDBG) Act of 1990 as implemented originally by Section 5082 of OBRA 1990. Through the original and subsequent allocations, funds are offered by the Administration of Children and Families (ACF), U.S. Department of Health and Human Services, to states with approved State Plans to increase the availability, affordability, and quality of child care.

(c) The AFDC At-Risk Program (also known as IV-A At-Risk Program) and the CCDBG eligibility requirements, specific for each of those funding streams, are described at N.J.A.C. 15B-1 and 10:15B-2 respectively. DHS shall operate these child care service programs through the coordination efforts of its Divisions of Youth and Family Services (DYFS) and Family Development (DFD), as described in rules set forth at N.J.A.C. 10:81 and 10:82. The policy provisions and terms in this chapter are general provisions which are applicable throughout all chapters N.J.A.C. 10:15A, 10:15B and 10:15C on child care services through the Department of Human Services.

1.-2. (No change.)

(d) New Jersey has the opportunity to expand, improve and develop child care services for the families of this State. A primary objective of the New Jersey Department of Human Services (NJDHS) is to offer families comprehensive child care services that will enable them to secure or maintain employment and thus become self-sufficient from public assistance benefit programs. Additionally, both the IV-A "At-Risk" and the CCDBG programs emphasize the availability of child care services for families under DYFS' Child Protective Services (CPS) supervision. For families serving as substitute care settings for protective services children (foster care) identified by DYFS, the CCDBG program emphasizes the availability of child care services. Such families must satisfy the eligibility criteria for those programs. Based on its extensive experience in child care and early education programs, the Department of Human Services sets forth the following principles for a comprehensive delivery system of child care services in the State.

1.-10 (No change.)

11. The Department promotes the development of employer-supported child care. DYFS provides technical assistance and consultation services to public/private/volunteer advocacy organizations seeking to promote employer-supported child care services throughout the State.

(e) Nothing in these rules shall be construed as conferring on a parent/applicant receiving child care services an entitlement to those services. If the fiscal or other resources necessary for child care service provision to a parent/applicant are unavailable, that individual shall not be deemed to have a right to such services and the individual and the county designated agency shall be released from all obligations for those services under these rules.

(f) (No change.)

(g) Each county shall coordinate child care service programs with units of local government; existing child care resource and referral agencies; with early childhood education programs in the county, including Head Start programs; preschool programs funded under Chapter 1 of the Education Consolidation and Improvement Act of 1981 (public Law 97-35); school and nonprofit child care programs (including community-based organizations receiving funds designated for preschool programs for disabled children); with organizations sponsoring before-and-after school activities; with the REACH/JOBS/FDP program; DYFS contracted centers; private providers; sectarian providers; and with Federal and/or State demonstration programs, such as the Goodstarts program, the REACH/JOBS Capital Expansion Program, and the Mini-Child Care Center program.

10:15-1.2 Definitions

The following words and terms, when used in this chapter and N.J.A.C. 10:15A, 10:15B and 10:15C, shall have the following meanings, unless the context clearly indicates otherwise.

"Approved home" means a family day care provider not registered pursuant to the Family Day Care Provider Registration Act (see N.J.A.C. 10:126), whose home has been evaluated and authorized for payment through the Department's child care service programs,

using the Self-Arranged Care Inspection and Interview Checklist (see N.J.A.C. 10:15A, Appendix B). Such providers may receive payment for a maximum of two nonsibling children, or all the sibling children of one family so long as the total number of children in the provider's care does not exceed *[eight]* ***five*** children ***under 13 years of age at one time***.

...

"Categories of care" means licensed *[center-based care]* ***child care center***, school-age child care programs, registered family day care, approved home care, in-home care, before-and/or after-school care, and summer camp.

...

"Child care center" means any home or facility, by whatever name known, which is maintained for the care, development or supervision of six or more children under 13 years of age who attend for less than 24 hours a day.

"Child Protective Services (CPS)," formerly known as Protective Services, means services on behalf of any child, under age 18, considered at risk of abuse, neglect, or exploitation; or found to be abused, neglected, exploited or abandoned, as identified by DYFS. The term, unless otherwise specified, includes services provided to children in out-of-home settings, such as foster care.

"Co-payment" means a portion of the family income that is paid by the eligible family toward the cost of child care. The amount of the required co-payment is based on the family's annual gross income level, family size, hours of care needed, and number of children in care.

...

"Foster care" means DYFS approved out of home placement services designed to provide a substitute family for a child who needs care outside his or her home for a temporary or extended period of time, as part of a child protective services (CPS) case management plan. The DYFS foster care program also includes services provided to CPS children in para-foster care, children under the guardianship of DYFS and children surrendered to DYFS.

"Incapacitated parent" means a parent/applicant who has a permanent physical or mental defect, illness or impairment which is supported by medical evidence and/or recorded testimony of a licensed medical health care professional, and which must be of such a debilitating nature as to reduce substantially or eliminate his or her ability to care for the eligible child(ren).

...

"New Jersey Cares for Kids (NJCK) Child Care Certificate Program" means the child care certificate program funded primarily by the IV-A "At-Risk" and the CCDBG grants. Also known as the NJCK Program or the Certificate Program.

...

"Parent/applicant" means an individual who has applied for and/or receives assistance with child care services, on behalf of an eligible child, from the Title IV-A "At Risk" program or the Child Care Development and Block Grant Program.

"Protective services" (see Child Protective Services and/or Foster Care).

...

"Special circumstances child" means a child that is not under Division of Youth and Family Services CPS supervision who has been identified through a written referral from a county welfare agency, DYFS, legal, medical, social service agency, emergency shelter, public school or School Based Youth Services Program which indicates that the child is from a family experiencing medical or social problems or adverse living conditions and child care arrangements are required to help ameliorate the situation and/or prevent the placement of the child or other family member(s) outside the home. Children of teen parents are also considered a special circumstance.

10:15-1.4 Atmosphere of mutual respect

(a) Assistance and services through the child care service programs shall be rendered to all parents/applicants in an atmosphere of mutual respect between county designated agency employees and the families they serve.

(b) (No change.)

10:15-1.5 Nondiscrimination

There shall be no discrimination on grounds of race; color; religious affiliation; sex; national origin; ethnic background; marital, parental or birth status; or disability by the Department, its Divisions or the county designated agencies in the administration of the child care service programs.

10:15-1.6 Confidential nature of information

(a) Information about parents/applicants for child care service programs shall be used and disclosed only for the purposes directly connected with the administration of child care service programs, or for CPS children as permitted by N.J.S.A. 9:6-8.10a.

(b)-(c) (No change.)

10:15-1.7 Primary source of information

(a) Parents/applicants of child care service program benefits are in all instances the primary source of information about themselves and their families.

(b) It is the responsibility of the county designated agency to determine eligibility based on the information provided by the parent/applicant and, as necessary, to secure verification from secondary sources. Such verification shall be limited to those facts which are essential to establish eligibility and shall be obtained only with the known consent of the parent/applicant.

(c) The county designated agency worker shall explain to the parent/applicant that verification is necessary and that lack of consent on behalf of the parent/applicant to obtain the necessary verification shall make processing of the application/reapplication impossible.

10:15-1.9 Issuance and availability of manual

(a)-(c) (No change.)

(d) The director of the county designated agency shall make available copies of this manual to all staff members working with parents/applicants of child care service programs. Likewise, all updates to manuals shall also be issued to staff. The county designated agency has the responsibility and shall ensure that each staff member working with these service programs is thoroughly familiar with the manual's contents, and applies the required policy and procedures consistently.

(e) (No change.)

(f) This manual is a public document. It is important that all copies in use be up-to-date. It is available as follows:

1. Copies are available for examination or review during regular office hours on regular work days in the Department of Human Services; in the Divisions of Family Development and Youth and Family Services; and in each county, at the office of the county designated agency.

i. Specific policy material necessary for a parent/applicant or his or her representative to determine the basis for a case or administrative review request, or to prepare for a review, shall be provided to such persons without charge.

2.-5. (No change.)

6. Employment, education and training organizations (that is vocational/technical school, community colleges, JTPA offices) shall be furnished with a copy of this manual through written request to DFD.

7.-8. (No change.)

10:15-2.1 Department of Human Services responsibilities in child care service programs

(a) The Department of Human Services (DHS) is the lead State agency responsible for child care service program delivery in the State. DHS, through its Divisions of Family Development and Youth and Family Services, shall coordinate and supervise the administration of the Child Care and Development Block Grant (CCDBG) and IV-A "At Risk" (ARCC) programs.

(b)-(j) (No change.)

(k) For activities to improve the quality of child care, DHS shall enter into purchase of service contracts and/or grants with eligible entities through the competitive State process (request for proposal) or continuation funding. DHS invests in:

1.-2. (No change.)

3. Training and technical assistance to child care providers in areas such as, but not limited to, parental choice, management and early childhood development;

4. To increase the availability of early childhood development programs and to increase the availability of before- and after-school care services; *[and]*

5. To increase the availability of child care resources for teen parents*[.]* ***and***

6. To provide consultation and referral services to parents.

10:15-2.2 Divisional responsibilities

(a) The Division of Family Development shall be responsible for the following activities in the administration of DHS child care service programs.

1. (No change.)

2. The contract, programmatic and fiscal supervision of the certificate system with the 21 community based organizations or county government offices which will administer the certificate program at the county level;

3. (No change.)

4. Providing for a case/administrative review appeals process through Divisional proceedings when situations concerning certificate parents/applicants are not resolved at the level of the local county designated agency;

5. Submission of required reports to the Federal Administration for Children and Families on the IV-A "At-Risk" and CCDBG child care programs;

6. Issuance of and updates to the manual, and maintenance of a current mailing list for dissemination of manual revisions; and

7. Periodically conducting a local market survey of child care costs for the various types of child care arrangements for full or part-time care.

(b) The Division of Youth and Family Services has responsibility for the following types of activities in the child care service programs:

1. (No change.)

2. Collaboration with the Division of Family Development in the development of policies and procedures for the child care service programs;

3. The administration and supervision of the ARCC related purchase of service contracts with child care providers*[.]***; and***

4. The administration and supervision of contracts which are established with CCDBG funds set aside to establish, expand or conduct early childhood development and/or school-age child care programs and to improve the quality and availability of child care.

10:15-2.3 County designated agency responsibilities

(a) Each county designated agency shall:

1.-13. (No change.)

14. Issue the appropriate forms and materials to eligible parents/applicants for receipt of provider services;

15. (No change.)

16. Provide for due process for parent/applicant complaints and provider concerns. Issues not resolved at the local county agency level may be taken to the Divisional level for a case/administrative review;

17. Establish written agreements for services among the county designated agency, the parent/applicant, and the provider regarding agreed-upon arrangements, co-payment responsibilities, and the submission of vouchers for payment of service;

18. Determine payment to provider(s) from the program and the amount of the co-payment paid by the parent/applicant;

19. Establish an agreement between the county designated agency and the DYFS District Office in the county for children in child protective services under DYFS supervision including children in foster care under the supervision of DYFS*[.]***;***

20.-21. (No change.)

22. Review the attendance forms and certify them for payment, for children in the care of providers participating in the child care service programs;

23. Provide information on the certificate program operation to parents/applicants and the community;

24.-31. (No change.)

10:15-2.4 Provider responsibilities

(a)-(b) (No change.)

(c) The provider shall complete vouchers with child(ren)'s attendance data, obtain the parent's/applicant's signature and send vouchers to the county designated agency within three business days of closing of reporting payment periods.

(d) (No change.)

(e) The provider shall ensure that no other public subsidy is received for the same period for the eligible children.

(f) The provider shall return all overpayments to the county designated child care agency.

(g) The provider shall provide 10 day notice to parents/applicants and to the county designated agency when a child will be terminated.

(h) The provider shall comply at all times with regulatory requirements for licensure of child care centers, registration of family day care homes or the authorization of approved homes as appropriate and as defined in N.J.A.C. 10:15-1.2.

10:15-2.5 Parent/applicant responsibilities

(a) The parent/applicant shall:

1.-6. (No change.)

7. Be responsible for all child care provider costs in excess of the maximum allowable payment for which *[they are]* ***the parent/applicant is*** eligible as indicated in N.J.A.C. 10:15A-1.2(c)*[.]***; and***

8. Comply at all times with the program eligibility requirements, pertaining to employment, training, education or child protective service status, and income eligibility requirements while in receipt of services (see N.J.A.C. 10:15A, 15B, 15C).

10:15A-1.1 Child Care Service Program availability

(a) As funding and Federal criteria permit, and to the extent that such child care is necessary to permit an ARCC eligible family member to accept employment or to remain employed, or to permit a CCDBG eligible family to obtain or participate in work/training or educational activities, child care service benefits are available based on the individual needs of each family. Additionally, child care services are also available for children under DYFS child protective services (CPS) supervision including children in foster care also supervised by DYFS, if child care services are necessary as part of the child's treatment plan. Payments through the child care service programs for child care shall not be made for care provided by the child's own parents, legal guardians, or members of the child's family unit, on the basis of their responsibility of caring for their own child(ren). Child care service programs include the IV-A "At-Risk" Program (see N.J.A.C. 10:15B-1) and the Child Care and Development Block Grant (CCDBG) Program (see N.J.A.C. 10:15B-2).

1.-2. (No change.)

3. The waiting list shall be kept by the county designated agency according to the dates the application was received by the agency and the family was determined to be eligible to receive services from the program, by priority group status (see N.J.A.C. 10:15B-1.1(c), 2.1(e)), and by the family's annual gross income level (see N.J.A.C. 10:15B-1.2(b) and 2.2(b)).

4. The waiting list shall be reviewed and waiting list families re-evaluated for service when resources are available. If the family who is next on the waiting list remains eligible and is unable to utilize the subsidy when it becomes available, the agency proceeds to the next family on the list.

5. Families found eligible to participate who are provided ARCC or CCDBG services shall receive a child care subsidy for up to 12 consecutive months without a redetermination of eligibility if the need for the service remains, the program eligibility criteria are met, and resources remain available.

i. A child shall not continue to receive a subsidy if the need for service no longer exists.

ii. An exception may be made in the CCDBG program in the case of loss of employment or for non-participation in a training/education activity by the parent/applicant. In such situations, the child(ren) may be continued in child care for a period not to exceed one month, so the parent may actively seek employment. If the parent/applicant fails to obtain employment and/or begin participa-

tion in a training/education program at the end of the one month period, then the family is no longer eligible to receive child care services from this program. In the ARCC program, after loss of employment, child care may be continued for up to one month if new employment, scheduled to begin by the end of the month, is secured.

(b) To be eligible for services through the child care services programs, a child must:

1.-2. (No change.)

3. Be under the child protective services supervision of DYFS; or

4. Reside with a family where one parent is working (ARCC and CCDBG) or attending a training/education program (CCDBG only) and the other parent is incapacitated as set forth in N.J.A.C 10:15-1.2.

(c) (No change.)

(d) The parent/applicant and the county designated agency, upon request of the parent/applicant, will mutually arrange for child care for the parent/applicant's child(ren) while the individual is employed full-time (ARCC and CCDBG) or participating in full-time educational or work/training activity (CCDBG only), or for a DYFS supervised foster care child (CCDBG only) or for children under the child protective services of DYFS, who reside with their natural parent(s) (ARCC and CCDBG). Parental choice from among categories of care or types of providers is guaranteed to the extent practicable under Federal and State laws and regulations.

1. Child care arrangements shall be in the best interests of the child and parent/applicant and shall consider the individual needs of the child, including the reasonable accessibility of the care to the child's home and school, and the appropriateness of the care to the age and special needs of the child.

2. Child care arrangements shall be selected and finalized by the parent/applicant. When selecting a child care provider the parent/applicant shall be informed that the hours of care for which the program will issue payment shall be reasonably related to the hours of participation in the education/training activity (CCDBG) or employment (CCDBG and ARCC) as indicated by the parent/applicant.

3.-4. (No change.)

5. To the extent that fiscal or other resources necessary for child care provision are available, child care is available to the extent that child care is necessary to permit a member of the family to accept or retain full-time employment (ARCC) or to participate in full-time educational or work/training activities (CCDBG only) if the family meets the income eligibility level; and in the CCDBG program for children under the child protective services supervision of DYFS, including children in foster care, needing child care as part of the child's treatment plan.

(e) Refusal of child care benefits may be inferred if the applicant does not select a child care provider or notify the county designated agency of *[their]* ***the parent's/applicant's*** need for child care referral services within 15 calendar days of the date the county designated agency*[;]* informs the *[family]* ***parent/applicant*** that *[they are]* ***he or she is*** eligible for services through these child care programs***;*** fails to select a child care provider after the receipt of child care referrals or fails to notify the county designated agency of the need for additional child care provider referrals; does not provide the information necessary for determining eligibility and co-payment amount within the timeframe specified by the county designated agency, including verification of earnings; does not sign and/or return the completed Parent/Applicant/Provider Agreement for the receipt of care; does not co-sign the child care voucher; or fails to comply with any other program eligibility requirement of N.J.A.C. 10:15, 10:15A, 10:15B or 10:15C.

1-3. (No change.)

(f) Parents/applicants of child care service programs are entitled to a case review conducted by the county designated agency and/or an administrative review conducted by DFD and notices through the county designated agency on issues concerning the appropriateness of, denial of, prompt issuance of, or intended actions to terminate or reduce child care benefits.

1. (No change.)

2. If the individual has been receiving child care benefits and is awaiting a review concerning those benefits because such benefits were reduced, he or she is not entitled to receive child care benefits at the prior unreduced level. Benefits shall continue at the determined reduced level pending the review. If the individual had not been receiving any child care benefits and is awaiting a review due to nonreceipt of child care benefits, he or she is not entitled to receive any child care benefits pending the review. If the individual had been receiving child care benefits and is awaiting a review concerning those benefits because such benefits were terminated, he or she is not entitled to receive child care benefits pending the review.

3. If a particular issue is not resolved at the county agency level, an administrative case review to be conducted by DFD may be requested for those participants receiving care through the certificate program or a hearing shall be provided through DYFS for those participants receiving care through contracted child care services in accordance with N.J.A.C. 10:120-3.

10:15A-1.2 Payment policies

(a) (No change.)

(b) Payment for care of school-aged children shall continue to be made at the part-time rate during recognized vacations and holidays during the school year, for example, Christmas, spring vacation, and so forth, unless the parent/applicant requires full time care *[year round due to their]* ***during these periods due to his or her*** work schedule. Payment for the care of school-aged children attending care full-time during summer vacation periods shall be made at the full-time rate.

(c)-(d) (No change.)

(e) The following conditions must be met for receipt of child care service program benefits:

1. The parent/applicant shall request child care benefits and provide the information necessary, including verification of earnings, for determining eligibility and co-payment and the family meets the financial eligibility requirements for either the IV-A "At-Risk" program or the CCDBG program as set forth at N.J.A.C. 10:15B-1 and N.J.A.C. 10:15B-2.

2. The parent/applicant shall sign an agreement covering the period during which the child care is to be provided;

3. The parent/applicant shall select a provider as set forth in the agreement;

4. The parent/applicant shall pay the required co-payment (see N.J.A.C. 10:15C-1.1(a)1 for the exception to co-payment) to the provider of care; and

5. The parent/applicant shall report changes in circumstances to the county designated agency.

(f) The family is not eligible for child care for any remaining portion of the 12 month period if the parent/applicant:

1. Terminates full-time employment (ARCC and CCDBG)or training or educational programs (CCDBG only), or the wages/income exceed eligibility levels;

2.-3. (No change.)

(g) Contingent upon compliance with applicable Federal eligibility criteria unique to ARCC and CCDBG as set forth in N.J.A.C. 10:15B-1 and N.J.A.C. 10:15B-2, if the parent/applicant loses a job (ARCC and CCDBG) and/or ends or no longer attends *[their]* ***his or her*** training/education activity (CCDBG only) and then begins employment and/or another training/education activity (CCDBG only) within one month of the loss of the previous job and/or training/education activity, the family can qualify for the one month of care during the transition between jobs, and/or training/education activities (CCDBG only), as well as for the remaining portion of up to 12 months in the child care eligibility period. (CPS and foster care children shall be treated in accordance with N.J.A.C. 10:15A-1.5(d).)If the individual becomes eligible again, he or she must reapply.

10:15A-1.3 Provider requirements

(a) Payments to providers of child care through child care service programs are available according to the requirements of this section.

(b) To qualify for child care payments, a child care center or program shall meet one of the following requirements as set forth at N.J.A.C. 10:122-*[2]***1.2***, Manual of Requirements for Child Care Centers*[,]* (N.J.S.A 30:5B-1 through 15); (see also N.J.A.C. 10:81-14.18(f)1):

1. Centers providing care for infant, preschool and school-age children up to the age of 13 years, shall be licensed by DYFS, Bureau of Licensing *[or shall]***,*** have a letter of exemption from DYFS, Bureau of Licensing ***or be exempt from licensure or excluded from the definition of a child care center***;

2. Until such time as the Division of Youth and Family Services' licensing regulations for this type of care are implemented, the child care programs for school-age children shall meet local occupancy building and fire codes and shall have satisfactorily completed an inspection using the DHS' "School-Age Child Care Interim Guidelines Checklist" (see Appendix A, incorporated herein by reference); or shall be operated under the auspices of the public school system or a DYFS contract; or

3. Summer camps shall be approved by the New Jersey Department of Health *[(see N.J.A.C. 8:25)]***, ***pursuant to N.J.S.A. 26:12-1 et seq. and N.J.A.C. 8:25****.

(c) (No change.)

(d) Providers of family day care who are not registered under (c) above shall be approved by the Department of Human Services in order to qualify for payment through any child care service program. Unregulated relatives, friends or neighbors are eligible for approved home status.

1. (No change.)

2. As an approved home, providers may receive payment for a maximum of two nonsibling children or for all the sibling children of one family so long as the total number of children in the home does not exceed *[eight]* ***five*** children ***under 13 years of age at any one time****.

(e)-(f) (No change.)

10:15A-1.4 Payment methods

(a) (No change.)

(b) Vendor payments to providers are the primary method for issuing child care payments in the child care service programs. Under this method, a voucher is issued to the child care provider after the completion and signing of a Parent/Applicant/Provider Agreement. The completion of this agreement permits the provider to receive an initial prospective monthly payment. To receive subsequent payments, the provider completes the voucher form, lists the dates of care, signs the voucher, secures the parent's signature and returns it to the agency responsible for issuing payment. Upon review and authorization of the voucher information, the agency issues a child care payment to the provider.

(c) (No change.)

10:15A-1.5 Requirement of co-payment

(a) Each family receiving child care is required to contribute a co-payment toward the cost of such care.

1. The exception to the co-payment requirement applies to children under child protective services supervision as identified by DYFS (see N.J.A.C. 10:15-1.2) including those living in a substitute care setting under the custody of DYFS in the CCDBG program. The co-payment for CPS children may be waived in CCDBG on a case by case basis; such a waiver is granted by the DYFS District Office (DO). The standards used by DYFS will incorporate, but not necessarily be limited to situations where:

i. A parent refuses to pay, is uncooperative in providing income information, or is otherwise uncooperative with the treatment *[of plan of]* ***plan for*** the child; or

ii. There is a court order prohibiting or limiting parental involvement with the child; or

iii. One parent in a two parent family cannot be located; or

iv. The parent is unable to pay and to require the parent to pay will place the family at risk of homelessness; or

v. The parent is unwilling or unable to pay, and to pursue payment would place the child, the siblings or the case plan in jeopardy.

2. Additionally, no co-payment is required for purposes of other Departmental child care programs if the family has children in care through the CCDBG or IV-A At-Risk programs and the family is making a co-payment for two children under either of these child care program requirements.

(b) A co-payment scale established by the Department of Human Services will provide for some level of contribution by most parent/applicants receiving child care. The co-payment scale shall consider: family income, family size, hours of care needed, and number of children in care. The co-payment scale is set forth at N.J.A.C. 10:15C-1.1(d).

(c) Individuals who fail to cooperate in paying the required co-payment will, subject to appropriate notice requirements and, if requested, a case or an administrative review as set forth at N.J.A.C. 10:15A-1.1(f), lose eligibility for child care benefits for so long as back co-payments are owed, unless satisfactory arrangements are made with each provider to make full payment of arrearages.

(d) In the CCDBG program, children under the child protective services (CPS) supervision of DYFS, including foster care children, shall not be terminated from services until:

1. The referring DYFS District Office (DO) or Adoption Resource Center (ARC) has been notified;

2. The referring DO and/or ARC maintains the responsibility for making alternate child care arrangements as deemed appropriate; and

3. (No change.)

(e) In the CCDBG program, any emergency termination of service initiated by a child care provider of a DYFS CPS child, including foster care, shall be reported to the DYFS DO/ARC Liaison.

10:15B-1.1 Description of IV-A "At-Risk" Program

(a) (No change.)

(b) Child care assistance is also available to a child who is under the child protective services of DYFS and who resides in *[their own home with their]* ***his or her own home with his or her own*** parents whose income meets the definition of low income as set forth in N.J.A.C. 10:15B-1.2(b).

(c) Services shall be provided to the extent of the State's entitlement to Federal monies, by targeting those most "at risk" of becoming AFDC-dependent. Groups identified as most "at risk" for participation include:

1. Families who are former AFDC recipients and who have completed their 12-months of REACH/JOBS/FDP transitional child care eligibility (see N.J.A.C. 10:81-14.18);

2. Families who are ineligible for Federal REACH/JOBS/FDP transitional child care benefits;

3. (No change.)

4. Families who have children identified as being in need of child protective services (excluding foster care children) under CPS supervision of DYFS; or, who are at risk of becoming homeless; or, who are teen parents (not on AFDC) who are employed and otherwise eligible for IV-A "At Risk" assistance.

10:15B-1.2 Eligibility for IV-A "At Risk" Child Care (ARCC) Program

(a) (No change.)

(b) Families shall be working low-income families or a working low income family that has a child in child protective services under the supervision of DYFS and who resides in the family's home.

1. For program entrance "low income" families are defined for purposes of this program as families whose gross annual income for the family size is at or below 200 percent of the Federal Poverty Income Guidelines published annually in the Federal Register (reference the Federal Register, Vol. 59, No. 28, dated February 10, 1994, page 6277). Subsequent updates to these Guidelines in the Federal Register will be published as a public notice by the Department in the New Jersey Register.

2. The annual gross income of the family must fall at or below 200 percent of the Federal Poverty Income Guidelines for the family size to establish initial income eligibility.

i. Priority attention shall be given to those families at the lower end of the income spectrum, that is, those at or below 150 percent of poverty will be given highest priority and those at 175 percent of poverty will be given the next highest priority.

3. Families may remain eligible under the IV-A At-Risk Program as long as the family's annual gross income, for the family size, does not exceed 75 percent of the State's median income (SMI) for a family of the same size. (The SMI for states is published by the Federal Administration for Children and Families in the Federal Register. The SMI was last published in the Federal Register, Vol. No. 53, No. 64, April 4, 1988. Subsequent updates to the SMI will be published as a public notice by the Department in the New Jersey Register.)

(c)-(g) (No change.)

(h) *[An eligible family shall be]* ***A family is also eligible to apply for benefits from this program if it is*** a two parent family where one parent who is working and the other is incapacitated, as defined in N.J.A.C. 10:15-1.2.

(i) Families shall make a co-payment toward the cost of care in accordance with N.J.A.C. 10:15C. The exception to the copayment requirement exists when the child is identified as under the protective services supervision of DYFS as defined at N.J.A.C. 10:15-1.2. A co-payment will be assessed for such children but may be waived on a case by case basis by the DYFS District Office(DO) or Adoption Resource Center (ARC) as delineated at N.J.A.C. 10:15A-1.5(a).

10:15B-2.1 Description of CCDBG Program

(a) The Child Care and Development Block Grant Program provides low and moderate income families with the child care assistance necessary to find and afford quality child care for their children or for children who are under DYFS child protective services (CSP) supervision including children in DYFS foster care placement.

(b) (No change.)

(c) CCDBG assistance is intended for "low and moderate income" families with a parent(s) who is working or attending a training or education program, or families who have a child under the supervision of DYFS in child protective services*[;]**,* including foster care.

1. "Low income" for purposes of the CCDBG Program for families receiving services is defined as an annual gross family income for the family size that does not exceed 75 percent of the State's median income (SMI) for a family of the same size if the family has been receiving child care services through Departmental child care programs. "Low income" for purposes of the CCDBG program for new applicant families is defined as an annual gross family income for the family size that does not exceed 60 percent of the SMI for a family of the same size. (The SMI for states is published by the Federal Administration for Children and Families in the Federal Register. The SMI was last published in the Federal Register, Vol. 53, No. 64, April 4, 1988. Subsequent updates to the SMI will be published as a public notice by the Department in the New Jersey Register.)

(d) Priority consideration and placement of children through CCDBG assistance is given to children who are from families with "very low income," as well as children who have been identified as child protective service children under the supervision of DYFS, including foster care, as having special needs or as having special circumstances (see N.J.A.C. 10:15-1.2 for definitions of a special needs or special circumstances child).

1. Families with "very low income" are defined as families with incomes at or below 185 percent of the Federal Poverty Income Guidelines, as determined by family size.

(e) Groups identified for priority CCDBG participation include:

1. Children who are under child protective services supervision, including foster care, as identified by the Department's Division of Youth and Family Services (DYFS) and defined at N.J.A.C. 10:15-1.2.

2. Children identified as having special needs (see N.J.A.C. 10:15-1.2) and/or in special circumstances, that is, a child that is not under DYFS supervision who has been identified through a written referral from a county welfare agency; DYFS, legal, medical, or social service agency; emergency shelter; School Based Youth Services Program or public school which indicates that the child is from a family experiencing medical or social problems or adverse living conditions. Such children require short-term special child care arrangements to help to stabilize or to ameliorate the situation and/or prevent the placement of the child or other family member(s) outside the home. Children of teen parents are also considered special circumstances children.

3. Children in families with very low income at or below 185 percent of the Federal Poverty Income Guidelines.

10:15B-2.2 Eligibility for CCDBG Program

(a) Families shall be in need of CCDBG child care assistance in order to remain employed or accept full-time employment or to attend full-time educational and/or work/training programs; or the family has a child in need of child care services who is under the supervision of DYFS in child protective services, including foster care.

(b) The child(ren) shall be residing with a family whose annual gross income does not exceed 75 percent of the State's median income for a family of the same size (see N.J.A.C. 10:15B-2.1(c)) for families who have been receiving child care services through other Departmental child care service programs; or be residing with an applicant family whose annual gross income does not exceed 60 percent of the SMI for a family of the same size.

(c) The child(ren) under protective service supervision, including foster care, where child care has been identified as part of the case plan to ensure that such children receive necessary child care services.

(d)-(f) (No change.)

(g) Families shall make a co-payment toward the cost of care in accordance with N.J.A.C. 10:15C. The exception to the copayment requirement only exists in the CCDBG program when the child is identified as one who is in child protective services under the supervision of DYFS (see N.J.A.C. 10:15-1.2), including foster care. Co-Payment fees for these children may be waived on a case by case basis by the DYFS DO or the DYFS Adoption Resource Center (ARC) as delineated in N.J.A.C. 10:15A-1.5(a).

(h) *[The child(ren) shall reside with a family where]* ***A family is also eligible to apply for benefits from this program if*** one parent is working or attending a training/education program and the other parent is incapacitated, as defined in N.J.A.C. 10:15-1.2.

10:15C-1.1 Co-payment procedures

(a) All eligible families shall pay a fee toward the cost of child care services. This fee is termed a co-payment.

1. The exception to the co-payment requirement exists in the CCDBG program when the child is identified as under DYFS child protective services supervision (see N.J.A.C. 10:15-1.2), including foster care. The co-payment for CPS children including foster care may be waived on a case by case basis in the CCDBG program; such a waiver is granted by the DYFS District Office (DO) or the DYFS Adoption Resource Center (ARC) as delineated in N.J.A.C. 10:15A-1.5(a).

2. Additionally, no co-payment is required for purposes of the other Departmental child care programs (for example, the Social Services Block Grant (SSBG) child care program) if the family has children in care through IV-A At-Risk or CCDBG and the family is making a co-payment for two children under that program's requirements. The county designated agency shall verify and document the facts concerning co-payment circumstances under the IV-A At-Risk and CCDBG program. The county designated agency shall make contact with the appropriate agency(s) in the county assessing co-payment for the other respective Departmental child care programs and inform that agency that the requirement for the co-payment has been met under either the CCDBG or IV-A At-Risk program.

(b) By the adoption of a Statewide co-payment scale for child care service programs provided to families, the programs seek to:

1. In accordance with the eligibility criteria of CCDBG or IV-A At Risk, enable an eligible family to accept and maintain employment and/or to participate in work/training or educational activities through child care service program aid or to provide child care services to a child in protective services, including foster care, as identified by DYFS;

2. (No change.)

3. Require that all families receiving child care service program benefits be assessed and/or pay a portion of the cost of care based on ability to pay, as required by the Omnibus Budget Reconciliation Act of 1990 (Public Law 100-508). However, the co-payment for CPS children, including foster care, may be waived on a case by case basis in the CCDBG program; such a waiver is granted by the DYFS District Office (DO) or DYFS Adoption Resource Center (ARC) as delineated at N.J.A.C. 10:15A-1.5(a).

(c) The co-payment assessed for the family is compiled into one monthly fee for the entire family. Once assessed, the total monthly co-payment is deducted from the amount to be paid by the county child care agency to only one provider rendering services to the family (see N.J.A.C. 10:15C-1.3). This assessed co-payment for child care services is then paid directly by the parent/applicant to the provider of care; any remaining balance of the cost of care, up to the maximum rates established by the Department (see N.J.A.C. 10:15A-1.2(c)), is paid by the county child care agency. The child care co-payment policy and procedures are applicable for all types of care arrangements available through the child care service programs including:

1.-5. (No change.)

(d) The amount of the required co-payment is based on the family's annual gross income level, family size, hours of care needed, and number of children in care. Assessed co-payments are apportioned monthly and are due for the entire period of time that subsidized child care assistance is received. Holidays, emergency closings, absences, and starting or ending dates of child care falling within any part of the month do not exclude or reduce the required monthly co-payment. There are two co-payment scales:

Tables I and II (No change.)

(e) The criteria for determination and re-determination of the co-payment are as follows:

1. Family size, which consists of the parent/applicant, the parent's/applicant's spouse and all children for whom the parent/applicant is a legal guardian. Family size may also include dependent children who are over the age of 18 or other adults who are not legally responsible for the children but who are dependent upon the parent/applicant if the parent/applicant so chooses to include these family members in the application for child care services.

2. Family income, which includes all gross earned and unearned income received by all members of the family unit defined in (e)1 above. The gross annual family income amount must be verified by wage stubs or similar documentation as a condition of receiving child care benefits; and

3. (No change.)

(f) Once the co-payment is determined, it will remain unchanged for the duration of the eligibility period (up to 12 months) unless there is a change in family size, gross family income or a change in care from full-time to part-time or vice versa. The participant must notify the county designated agency of any changes occurring in the family related to family size, income, work status or training/educational program attendance. The county designated agency shall then determine any changes in the co-payment based on reported circumstances affecting co-payment calculation.

1. An exception shall be made in the case of co-payment for school-age children. The county designated agency will determine a part-time co-payment in accordance with (e) above, for all school-age children, unless the school-age child is in full-time child care for the entire period of the 12 months Parent/Applicant/Provider Agreement. Only in this instance, the co-payment determination will be based on the full-time arrangement.

(g) The co-payment assessment is based on up to two children in care in a family. If more than two children in a family are in care, no co-payment is required for the third and subsequent children in the family. The co-payment is determined on a per month basis.

10:15C-1.2 Process for co-payment assessment

(a) The monthly co-payment is based on whether the care is full-time or part-time care, on the number of children (up to two per family) in the family needing such care through the program, and on the family's annual gross income level.

(b) If only one child is in care, the monthly co-payment is the payment which results from Table I or Table II at N.J.A.C. 10:15C-1.1(d). That co-payment is assessed on that family's size, the family's annual gross income, and whether the care is full-time or part-time care for that child, resulting in the co-payment from Table I or Table II.

(c) If two or more children in the family receive child care services through the Program, the monthly co-payment amount is a total payment for up to two children in the family receiving such services. The monthly co-payment sum equals the full co-payment assessed for the first child from Table I or Table II, plus one-half of the full assessed co-payment for the second child in care from Table I or Table II. The two children are selected for determination of the co-payment from all children in the family in care, based first, on the number of children in the family in full-time care arrangements.

1. If two or more children in the family are in full-time care arrangements, the full co-payment amount is assessed on two children in full-time care. A full co-payment amount is assessed for the first child in full-time care from Table I; to that co-payment amount is added one-half of the full-time co-payment amount for the second child in full-time care from Table I. The resulting total monthly co-payment equals one and one-half of the full-time co-payment amount from Table I based on the family's size and annual income level.

2. If at least one child in the family is in a full-time care arrangement and the second and subsequent children are in part-time care arrangements, the full monthly co-payment amount is assessed from Table I on the first child in full-time care; to that co-payment amount is added one-half of the part-time co-payment amount from Table II for the second child in part-time care. The resulting total monthly co-payment equals the full-time co-payment assessed amount from Table I plus one-half of the part-time co-payment amount from Table II.

3. If all children in the family are in part-time care arrangements, the full monthly co-payment amount is based on up to two children in care and is one and one-half times the part-time co-payment amount from Table II for the family's size and income amount.

10:15C-1.3 Provider's receipt of co-payment

(a) The total monthly co-payment is paid to only one provider of care based on the care arrangements of the family. That is, the total monthly co-payment is paid in total to the provider of the highest cost of care arrangement (that is, either the full-time care provider or the provider with the highest reimbursement rate per category of care). The following situations may result and the co-payment shall be distributed as follows:

1. (No change.)

2. If one child is receiving child care services through the Program but more than one provider is involved in giving care, the co-payment from Table I or Table II is paid by the parent/applicant to that child care provider who provides the highest cost care arrangement (see (a) above).

3. When two children are receiving child care services from the same provider, the total monthly co-payment amount is determined in accordance with N.J.A.C. 10:15C-1.2(c) above, and the sum total is paid by the parent/applicant to that provider of care. The total monthly co-payment is based on the respective hours of care (full-time or part-time) provided each child; the full assessed co-payment fee from Table I or Table II for the first child is added to one-half of the full assessed fee from Table I or Table II for the second child in care with the provider, for the total co-payment amount.

4. When both children are receiving different child care services from separate providers, the child care provider who provides either full-time care or receives the highest reimbursement rate per category of care, will receive from the parent/applicant the full amount of the total monthly co-payment assessed for both children from Table I or Table II based on the respective type of care provided (full-time or part-time care) for both children.

5. When both children are receiving the same child care services but from different providers (for example both receiving full-time care) the provider assessed at the highest cost of care arrangement

receives the full monthly assessed co-payment from the parent/applicant.

6. When a family has a child(ren) receiving child care services from the voucher program and another Departmental child care program(s), the county designated agency shall contact the appropriate agency to inform them that the family is receiving assistance from the voucher program. In these situations, the provider receiving a subsidy on behalf of the eligible children in the voucher program shall receive the total family monthly co-payment.

(b) (No change.)

(c) The county designated agency will determine a part-time co-payment for all school-age children, in accordance with N.J.A.C. 10:15C-1.1(e), unless the school-age child is in full-time child care for the entire period of the 12 month Parent/Applicant/Provider Agreement. In this instance, the co-payment determination will be based on the full-time arrangement.

10:15C-1.4 Collection, reporting and monitoring of the co-payment; notice of termination

(a) The child care provider will be responsible for the collection and reporting of all nonpayment of the co-payment fee(s) to the county designated agency.

(b) The county designated agency is responsible for advising the provider and the parent/applicant of the co-payment requirement, for training the provider and the parent/applicant in voucher completion, and for advising both the provider and the parent/applicant of the consequences of failure to make the required co-payments.

(c) Co-payment collection, monitoring, and procedures for late payment or nonpayment of co-payments and termination of child care benefits are as follows:

1. It is the responsibility of the child care provider to collect co-payments and report nonpayment of co-payments to the county designated agency in accordance with Departmental procedures. Whenever the child care co-payment has not been paid to the provider as required, the co-payment is considered unpaid.

i. In the event of nonpayment of the co-payment by the participant, the provider will provide notice to the county designated agency indicating the child(ren) for whom the participant failed to pay the required co-payment and the total amount owed by the participant. This action by the provider will initiate the process for terminating child care benefits.

ii. (No change.)

2. It is the responsibility of the county designated agency to monitor co-payment collection by responding to all notices of nonpayment of co-payments which are reported by the provider.

3. Following receipt of a notice from a provider indicating nonpayment of the assessed co-payment by the participant, the county designated agency worker shall:

i.-ii. (No change.)

4. The purpose of the letter in (c)3ii above is to provide written notice to:

i. Advise the parent/applicant of the amount of assessed co-payment monies which have not been paid;

ii. Advise the parent/applicant of the right to request and obtain a case or administrative review;

iii. (No change.)

iv. Serve as written confirmation for the provider and the county designated agency that child care services will be terminated due to the late or nonpayment status of the parent/applicant; and

v. Advise the parent/applicant to pay the required co-payment arrearages and to contact the county designated agency immediately if overdue co-payment(s) have been paid so that benefits may be continued.

5. Three copies of the notification of termination letter must be completed and signed by the agency worker. The agency worker will:

i. Send the original to the parent/applicant;

ii. (No change.)

iii. Retain an agency copy.

6. In the CCDBG program child protective services children including foster care children identified by DYFS shall not be terminated until the conditions at N.J.A.C. 10:15A-1.5(d) are met.

7. When child care services are terminated due to nonpayment of the co-payment, the parent/applicant of a child receiving child care services may request a case or administrative review. If child care services are terminated, no payment shall be rendered by the agency under the program from the date of termination until a review is held and a final determination is made (see N.J.A.C. 10:15A-1.1(f)).

i. In all cases where a case review is requested of the county designated agency, the agency must adhere to the established procedures of the program. If the issue is not resolved through the due process proceedings at the county designated agency level, an administrative review may be requested at DFD for those participants receiving care through the certificate (voucher) process or a fair hearing through DYFS for those receiving care through contracted child care services (see N.J.A.C. 10:120-3).

(a)

DIVISION OF DEVELOPMENTAL DISABILITIES

Determination of Need for a Guardian

Readoption with Adopted New Rules: N.J.A.C. 10:43

Proposed: July 18, 1994 at 26 N.J.R. 2838(a) (see also 26 N.J.R. 3341(a)).

Adopted: November 16, 1994 by William Waldman, Commissioner, Department of Human Services.

Filed: November 16, 1994 as R.1994 d.611, **without change.**

Authority: N.J.S.A. 30:1-12 and 30:4-165.4 et seq.

Effective Date: December 19, 1994.

Expiration Date: December 19, 1999.

Summary of Public Comments and Agency Response:

No comments received. N.J.A.C. 10:43 expired August 21, 1994, pursuant to Executive Order No. 66(1978). In accordance with N.J.A.C. 1:30-4.4(f), the expired rules with amendments are adopted herein as new rules.

Full text of the adopted new rules can be found in the New Jersey Administrative Code at N.J.A.C. 10:43.

Full text of the adopted amendments follows:

10:43-1.3 Definitions

The following words and terms shall, for the purposes of this chapter, have the meanings contained in this section unless the text clearly indicates otherwise.

. . .

"Functional service unit" means any of the following components of the Division: a Developmental Center, a Regional Office of Community Services or the Special Residential Services.

10:43-4.2 (Reserved)

(b)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Transportation Services

Adopted Amendment: N.J.A.C. 10:50-2.2

Proposed: October 3, 1994 at 26 N.J.R. 3929(a).

Adopted: November 21, 1994 by William Waldman, Commissioner, Department of Human Services.

Filed: November 23, 1994 as R.1994 d.622, **with a technical change** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4D-6b(15); 30:4D-7, 7a, b and c; 30:4D-12; 42 CFR 431.53 and 440.170(a).

Agency Control Number: 94-A-41.

Effective Date: December 19, 1994.

Expiration Date: February 27, 1996.

Summary of Public Comments and Agency Responses:

The Division received one comment from the following person pertaining to the proposed amendments:

Joyce Morse, Director of Children's Services, The Matheny School and Hospital, Peapack, NJ

COMMENT: Ms. Morse wrote in support of the proposed amendment, indicating that the revisions to the current rate of reimbursement will help Medicaid recipients to access needed medical services when transportation by ground ambulance and invalid coach is required.

RESPONSE: The agency is proceeding to adopt the amendment.

Summary of Changes between Proposal and Adoption:

The Division, on its own initiative, is changing one HCPCS procedure code upon adoption. The code, A0020 22, is being changed to Y0004 to reflect current administrative practice. This technical change was inadvertently omitted from the proposal. The increased fee ($2.00) is the same amount proposed. There is no additional burden being placed upon providers, because the fee for the service remains the same as proposed.

Full text of the adoption follows:

10:50-2.2 HCPCS procedure codes and maximum fee schedule

HCPCS Mod. Code	Description	Maximum Fee Allowance
	(a) AMBULANCE SERVICE	
A0010	Ambulance Service, Basic Life Support (BLS) Base Rate, Emergency Transport, One Way	$58.00
A0020	Ambulance Service, (BLS) Per Mile, Transport, One Way	1.50
[A0020 22] **Y0004***	Ambulance Service, (BLS) Per Mile, Transport, One Way	2.00
	NOTE: The higher rate is applicable for trips in excess of 15 miles one way, beginning with the first mile. The higher rate is applicable to both the one way and to the return trip.	
A0040	Ambulance Service, Air, Helicopter Service, Transport	B.R.
A0070	Ambulance Service, Oxygen, Administration and supplies, Life sustaining situation	12.00 per occurrence
A0222	Ambulance Service, Return Trip, Transport	58.00
Y0005	Waiting Time—Ambulance Service—One Way Trip Only	
	¼ hour	2.50
	½ hour	5.00
	¾ hour	7.50
	1 hour	10.00
	NOTE: Reimbursable only on one way trips and only after 30 minutes have elapsed. It is reimbursable in ¼ hour increments. Maximum reimbursement for waiting time is $10.00 (1 hour).	
	(b) INVALID COACH SERVICE	
A0130	Non-Emergency Transportation: Wheelchair Van	25.00
	NOTE: Invalid Coach Service, One Way, Per Patient	
Y0002	Invalid Coach Service, Per Mile, One Way and Round Trip	1.50
Y0002 22	Invalid Coach Service, Per Mile, One Way and Round Trip, in excess of 15 miles one way	2.00
	NOTE: The higher rate is applicable for trips in excess of 15 miles one way, beginning with the first mile. The higher rate is applicable to both the one way and to the round trip.	
Y0010	Waiting Time—Invalid Coach Service—One Way Trip Only	
	¼ hour	1.25
	½ hour	2.50
	¾ hour	3.75
	1 hour	5.00
	NOTE: Reimbursable only on one way trips and only after 30 minutes have elapsed. It is reimbursable in ¼ hour increments. Maximum reimbursement for waiting time is $5.00 (1 hour).	
Y0060	Invalid Coach Service, Round Trip, Per Patient	50.00
Y0065	Extra crew differential, round trip	20.00
Y0070	Extra crew differential, one way	10.00
Y0075	Invalid Coach Oxygen	12.00 per occurrence

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Home Care Services

Accreditation of Private Duty Nursing Agencies

Adopted Amendment: N.J.A.C. 10:60-1.3

Proposed: July 18, 1994 at 26 N.J.R. 2840(a).

Adopted: November 21, 1994 by William Waldman, Commissioner, Department of Human Services.

Filed: November 23, 1994 as R.1994 d.623, **with technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4D-3h, 30:4D-6b(2), 7, 7a, b and c; 30:4D-12, 30:4E; 42 CFR 440.70, 170.

Agency Control Number: 94-A-14.

Effective Date: December 19, 1994.

Expiration Date: February 19, 1996.

Summary of Public Comments and Agency Responses:

No comments were received.

Summary of Changes between Proposal and Adoption:

The Division is removing the phrase at N.J.A.C. 10:60-1.3(b) which identifies that compliance with this rule would be required "within one year" from the date of adoption, and inserting, in lieu of that phrase, January 3, 1996, providing one year and three weeks to comply.

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

10:60-1.3 Providers eligible to participate

(a) (No change.)

(b) The voluntary non-profit homemaker agency, private employment agency and temporary help-service agency shall be accredited, initially and on an ongoing basis, by the Commission on Accreditation for Home Care, Inc., or the Community Health Accreditation Program.

1. Exception: A private duty nursing agency currently approved by the Division to provide private duty nursing services (except for the licensed home health agency which is exempt from the accreditation requirement) shall have up to *[one year from the adoption date of this amendment]* ***January 3, 1996*** to become an accredited agency and meet the Division's requirements for accreditation. New private duty nursing agencies applying to become Medicaid providers after *[the adoption of the amendment]* ***December 19, 1994*** shall conform to the accreditation requirement at the time of application.

(a)

DIVISION OF FAMILY DEVELOPMENT

Public Assistance Manual
AFDC-N Segment Eligibility of Aliens
Adopted Amendments: N.J.A.C. 10:81-2.6, 3.9 and 13.3
Adopted Repeal: N.J.A.C. 10:81-3.10

Proposed: October 3, 1994 at 26 N.J.R. 3930(a).
Adopted: November 16, 1994 by William Waldman, Commissioner, Department of Human Services.
Filed: November 16, 1994 as R.1994 d.612, **without change.**

Authority: N.J.S.A. 44:10-3.

Effective Date: December 19, 1994.
Operative Date: January 1, 1995.
Expiration Date: July 25, 1999.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

10:81-2.6 Eligibility factors other than need

(a)-(c) (No change.)

(d) Rules concerning Social Security numbers are as follows:

1.-2. (No change.)

3. The CWA shall obtain a supply of Social Security Form SS-5, sufficient to accommodate all AFDC applicants and eligible individuals who do not already have Social Security numbers. Upon application for AFDC, the applicant shall be required to sign as many SS-5 forms as needed for the eligible family. The IM worker shall complete Form SS-5 on the basis of information provided by the applicant. Completed forms shall be forwarded to the county's respective Social Security Administration District Office (SSA/DO). A copy of the SS-5 form shall be retained in the case record, and a copy given to the client if so requested.

i.-iii. (No change.)

4.-6. (No change.)

(e) (No change.)

10:81-3.9 Applicant in AFDC-C, -F and -N

(a) (No change.)

(b) The term applicant in AFDC-F and -N refers to natural or adoptive parents, not incapacitated, both of whom shall be required to execute the formal written application unless one such parent is not available for reasons beyond the family's control. This parent shall be required to sign as promptly as he or she is available for such purpose. (See N.J.A.C. 10:82-1.5 and 2.13 relevant to companion cases.)

(c) To be eligible for AFDC-C, -F or -N, or AFDC-related Medicaid an individual shall be either a citizen of the United States or otherwise permanently residing in the United States under color of law, including any alien who is lawfully present in the United States as a result of the application of Section 207(c), Section 203(a)(7) (prior to April 1, 1980), Section 208, and Section 212(d)(5) of the Immigration and Nationality Act.

1. Each AFDC-C, -F or -N and AFDC-related Medicaid applicant shall, as a condition of eligibility, provide a written statement of citizenship or legal alien status. If the applicant(s) is not a United States citizen, he or she shall provide documentation, subject to verification, of satisfactory immigration status. When the applicant or other person for whom the application is being made is an alien, his or her legal status shall be verified through evidence provided by the applicant with the United States Immigration and Naturalization Service. (Refer to N.J.A.C. 10:81-13 for alien verification procedures through the Systematic Alien Verification for Entitlements (SAVE) program.)

i.-iv. (No change.)

2. Assistance through the AFDC-C, -F or -N segments and AFDC-related Medicaid shall not be granted to an illegal alien or to aliens admitted as students or visitors. However, United States citizen/lawfully admitted children of illegal aliens may still be eligible to receive AFDC-C, -F or -N segment benefits and AFDC-related Medicaid. The situations described in (c)2i through iii below serve as illustration of how to determine AFDC-C, -F, or -N status for U.S. citizen/lawfully admitted children of illegal aliens.

i. In the case of one illegal parent with U.S. citizen/lawfully admitted children, the children shall be eligible for AFDC-C due to parental deprivation (one parent is absent). The eligible unit will consist of the U.S. citizen/lawfully admitted children. There is no assistance payment for the illegal alien parent but his or her income shall be counted as available to the eligible unit in accordance with N.J.A.C. 10:82-2.9(d).

ii. If one parent is a legal alien, or a U.S. citizen and qualifies the children for AFDC-F segment, the children and legal alien/citizen parent shall be eligible under the -F segment. The other parent's income shall be counted as available to the eligible unit in accordance with 10:82-2.9(d) but his or her needs are not considered in determining the grant amount.

iii. If one or both parents are not legal aliens or legal alien/U.S. citizens and the parents do not meet the criteria to qualify the children for AFDC-F, the children may, if otherwise eligible, qualify for -N segment benefits if they are U.S. citizens/lawfully admitted aliens. If both parents are illegal aliens, the parents' income is counted as available to the eligible unit in accordance with N.J.A.C. 10:82-2.9(d) and the children form an -N segment unit of their own. If one parent is an illegal alien and the other parent is a legal alien/U.S. citizen, the children plus the legal alien/U.S. citizen parent form an AFDC-N segment unit.

3.-4. (No change.)

10:81-3.10 (Reserved)

10:81-13.3 Citizenship/alien status

(a)-(d) (No change.)

(e) AFDC-N segment cases are not subject to the requirements of the SAVE Program unless they are United States citizens or legal aliens eligible for food stamps or AFDC-related Emergency Assistance.

(b)

DIVISION OF FAMILY DEVELOPMENT

Assistance Standards Handbook
AFDC-N Segment Eligibility of Aliens
Adopted Amendment: N.J.A.C. 10:82-2.3

Proposed: October 3, 1994 at 26 N.J.R. 3932(a).
Adopted: November 16, 1994 by William Waldman, Commissioner, Department of Human Services.
Filed: November 16, 1994 as R.1994 d.613, **without change.**

Authority: N.J.S.A. 44:10-3.

Effective Date: December 19, 1994.
Operative Date: January 1, 1995.
Expiration Date: July 25, 1999.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

10:82-2.3 Income from eligible and noneligible individuals in the household

(a) (No change.)

(b) Noneligible individual: A noneligible individual is neither sanctioned nor required by law or regulation to be included in the eligible unit. When a noneligible individual is living in the household of an eligible unit, the income from that living arrangement to the eligible unit shall be treated in accordance with N.J.A.C. 10:82-4.3(c) if extensive personal services are provided, or N.J.A.C. 10:82-4.12. If the non-eligible individual is an illegal alien parent, (see N.J.A.C. 10:81-3.9), his or her income shall be considered available to the

eligible unit and shall be calculated in accordance with the stepparent deeming formula at N.J.A.C. 10:82-2.9(d).

(c) (No change.)

(a)

DIVISION OF FAMILY DEVELOPMENT

Notice of 1995 New Jersey Supplemental Security Income Payment Levels and of Administrative Change

N.J.A.C. 10:83-1.11

Take notice that, in accordance with N.J.A.C. 10:83-1.11, the Department of Human Services announces that the following payment levels are to be utilized in the Supplemental Security Income Program in New Jersey for the period January 1, 1995 through December 31, 1995. This change is effective January 1, 1995.

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

10:83-1.11 New Jersey Supplemental Security Income payment levels

(a) (No change.)

(b) New Jersey Supplemental Security Income payment levels are as follows:

Living Arrangement Categories	Payment Level
Eligible Couple	[1/1/94] **1/1/95**
Licensed Medical Facility (Hospital, Skilled Nursing Facility or Intermediate Care Facility) Publicly operated community residence of 16 or less	[$80/669.00] **$80/687.00***
Residential Health Care Facilities and certain residential facilities for children and adults	[$1173.36] **$1197.36**
Living Alone or with Others	[$694.36] **$712.36**
Living in Household of Another, Receiving Support and Maintenance	[$539.09] **$551.09**
Eligible Individual	
Licensed Medical Facility (Hospital, Skilled Nursing Facility or Intermediate Care Facility) Publicly operated community residence of 16 or less	[$40/446.00] **$40/458.00***
Residential Health Care Facilities and certain residential facilities for children and adults	[$596.05] **$608.05**
Living Alone or with Others	[$477.25] **$489.25**
Living with Ineligible Spouse (No other individuals in household)	[$694.36] **$712.36**
Living in Household of Another, Receiving Support and Maintenance	[$341.65] **$349.65**

*The lower figure applies when Medicaid payments with respect to an individual equal an amount over 50 percent of the cost of services provided in a month.

(b)

DIVISION OF YOUTH AND FAMILY SERVICES

Notice of Amended Rate of Personal Needs Allowance and of Administrative Change

N.J.A.C. 10:123-3.4

Take notice that the Division of Youth and Family Services is amending the rate of the personal needs allowance reserved by the owner or operator of each residential health care facility or boarding home for each Supplemental Security Income recipient residing therein, and the owner or operator of each residential health care facility for each General Public Assistance recipient residing therein. The amended rate is in the amount of at least $68.50 per month provided that the rate of the total 1995 Federal Social Security cost of living increase is 2.8 percent. No owner or operator or agent thereof shall interfere with the recipient's retention, use, or control of the personal needs allowance.

This notice is being given to inform the public that the Division of Youth and Family Services shall increase the rate of the personal needs allowance from $67.50 to $68.50 effective January 1, 1995. This increase is based on the total 1995 Federal Social Security cost of living increase and is consistent with an amendment to N.J.A.C 10:123-3.4 adopted on October 4, 1993 at 25 N.J.R. 4598(a), which authorizes the announcement of the personal needs allowance increase through public notice. Through this notice, in accordance with N.J.A.C. 1:30-2.7(c), N.J.A.C. 10:123-3.4(a) is changed to reflect this amended rate.

Full text of the changed rule follows (addition indicated in boldface **thus**; deletion indicated in brackets [thus]):

10:123-3.4 Amount

(a) The owner or operator of each residential health care facility or boarding home shall reserve to each Supplemental Security Income (SSI) recipient residing therein, and the owner or operator of each residential health care facility shall reserve to each General Public Assistance recipient residing therein, a personal needs allowance in the amount of at least [$67.50] **$68.50** per month, set according to (b) below, and noticed in the New Jersey Register and otherwise publicized, in accordance with (c) below. No owner or operator or agency thereof shall interfere with the recipient's retention, use, or control of the personal needs allowance.

(b)-(c) (No change.)

(c)

DIVISION OF YOUTH AND FAMILY SERVICES

Manual of Requirements for Family Day Care Registration

Adopted Amendments: N.J.A.C. 10:126-1.2, 2.2, 2.3, 2.4, 2.6, 3.2, 4.1, 4.2, 4.6, 4.8, 5.1, 5.2, 5.3, 5.4, 5.6, 5.7, 5.8, 5.9, 5.10, 6.1, 6.2, 6.3, 6.4, 6.5, 6.6, 6.8, 6.9, 6.13, 6.18 and 6.20

Adopted New Rule: N.J.A.C. 10:126-1.4

Proposed: August 1, 1994 at 26 N.J.R. 3144(a).

Adopted: November 21, 1994 by William Waldman, Commissioner, Department of Human Services.

Filed: November 23, 1994 as R.1994 d.625, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:5B-16 et seq.

Effective Date: December 19, 1994.

Operative Date: January 1, 1995.

Expiration Date: October 6, 1998.

Summary of Public Comments and Agency Responses:

The Division received written and oral public comments from five family day care providers, Terry Camoratto, of Sea Isle City and four others who wish to remain anonymous; Jean Paashaus; and the Family Day Care Organization of New Jersey (oral comment). The comments from the community organization, the Family Day Care Organization of New Jersey, are addressed last in the following summary.

COMMENT: Two commenters objected to the deletion of the definitions of the terms "cooperative agreement" and "fee." One commenter questioned the basis for the Division's statement that some 400 registered family day care providers are caring for children under cooperative agreements with parents for no fee.

RESPONSE: The Division disagrees. These definitions were deleted in order to comply with recent amendments to the Family Day Care Provider Registration Act (N.J.S.A. 30:5B-16 et seq.), enacted as P.L. 1992, c.13. The law formerly permitted providers to care for children

under cooperative agreements with parents to exchange child care services for no fee, without counting these children in the maximum limit of five children specified in the law. The amended law no longer permits such cooperative agreements in excess of five chidlren; the only exceptions permitted from the maximum limit of five children are for the assistant's or substitute's children in care for no payment, and for children who reside in the provider's home.

The family day care sponsoring organizations, which carry out the registration program under contract with the Division, estimated that approximately 10 percent of providers cared for children in these arrangements, amounting to 400 out of some 4,000 registered providers. The sponsoring organizations also reported that these arrangements were difficult to understand and monitor, with many providers misinterpreting or circumventing the regulations. The proposed amendments are clearer and simpler, and are intended to improve care by reducing overcrowding in family day care homes.

COMMENT: One commenter objected to the amended at N.J.A.C. 10:126-5.2(b) requiring physical examinations to be repeated upon renewal. The commenter suggested that such examinations should be required once a year.

RESPONSE: The Division disagrees. The cost of annual physical examinations would be burdensome for many providers, and would make it difficult for low-income providers to be registered. Further, the Division questions the need for such frequent examinations, since annual physical exams are not routinely recommended for the general population. The amendments are designed to strengthen the previous requirement, which only called for one physical examination upon initial application, without placing any undue financial burden on providers.

COMMENT: One commenter objected to the amendment at N.J.A.C. 10:126-5.2(f) requiring the inspector to have access to areas of the home that are not designated for use by children, in order to observe whether any hazards exist. The commenter suggested that this would infringe on providers' right to privacy.

RESPONSE: The Division disagrees. The amendments were designed to improve children's safety by ensuring that they are protected from hazards. Without access to a room or area, the inspector can not verify whether it is free of hazards. However, the inspector will not examine all furniture and equipment in areas not used by children nor examine personal belongings, but will simply determine whether a lock or barrier is needed to keep children from entering.

COMMENT: One commenter objected to the amendments at N.J.A.C. 10:126-5.2(g) requiring the alternate provider to attend the six-hour preservice training, as already required for the provider. The commenter also suggested that training in first aid and cardio-pulmonary resuscitation (CPR) should be required for all providers.

RESPONSE: The Division disagrees. These amendments were designed to ensure that the alternate provider receives the same training as the provider, since the alternate may be caring for children in the provider's absence up to 50 percent of the home's operating hours. The training will help the alternate know how to provide appropriate care for the children. While training in first aid and CPR would certainly be beneficial for providers, such training can be costly and lengthy, and is difficult to obtain in some areas of the state. The amendments include a recommendation at N.J.A.C. 10:126-4.2(h) to encourage providers to attend such training when circumstances permit.

COMMENT: One commenter objected to the rule at N.J.A.C. 10:126-5.7(a)6 that indicates the role of the Division's Institutional Abuse Investigation Unit (IAIU) in determining whether children in a registered family day care home are at risk of harm. The commenter suggested that this amendment treats family day care like an institution rather than a home.

RESPONSE: The Division disagrees. The IAIU investigates allegations of child abuse and neglect in out-of-home settings; family day care is considered an out-of-home setting because the enrolled children are not in their own homes while attending family day care. The Division has assigned the IAIU to investigate allegations of child abuse and neglect in registered family day care homes, as well as licensed child care centers and other facilities licensed or approved by the Division's Bureau of Licensing. This arrangement enhances communication between the IAIU and the Bureau, and permits more efficient administration of the registration program. It does not change the nature of family day care or affect the day-to-day care of children in registered family day care homes.

COMMENT: One commenter expressed concern about the amendments at N.J.A.C. 10:126-5.8(d) concerning possible corrective action that may be taken when the Division has determined that children in a family day care home are at risk of harm by an adult, other than the provider, living in the home. The commenter suggested that requiring the removal of such a person from the home one hour prior to the children's arrival until one hour after their departure would be difficult to enforce.

RESPONSE: The Division disagrees. Such action would only be taken in exceptional circumstances when the Division determined that it could be carried out without placing the children at risk, would require the provider's consent to the arrangement, and would involve intensive monitoring to ensure compliance.

COMMENT: Six commenters objected to the amendments at N.J.A.C. 10:126-6.1 concerning the maximum numbers of children permitted in the home. The commenters questioned the basis for limiting providers to a maximum of five children at one time, except for children who reside with the provider or with the alternate provider, substitute provider or provider assistant. Those commenters who are family day care providers urged the Division to permit providers to care for eight children at one time, regardless of the children's residence. One commenter suggested that the rules would be difficult to enforce and might expose providers to the media and to law enforcement in case of violations.

RESPONSE: The Division disagrees. The amendments are necessary to comply with recently amended legislation. Specifically, the Family Day Care Provider Registration Act (N.J.S.A. 30:5B-16 et seq., as amended by P.L. 1992, c.13) limits the maximum number of children permitted in a registered family day care home. The law permits no more than five children at any one time, except for children legally related to the provider and children of a substitute or assistant provider, who are in care under an employment agreement with the provider. In addition, the State Child Care Center Licensing Law (N.J.S.A. 30:5B-1 through 15) requires any facility caring for six or more children below 13 years of age to be licensed as a child care center, rather than a family day care home. Since the limit of five children is established by law, the Division does not have the authority to issue regulations that exceed this limit.

The regulations contained in the Manual of Requirements are designed to carry out the intent of the law. The regulations concerning the maximum number of children permitted in the home (N.J.A.C. 10:126-6.1) maintain the limit of five children established by law. In addition, the regulations and the recently proposed amendments set limits on the number of additional children permitted under the above-noted exceptions. Up to three additional children are permitted if they reside with the provider, or if they reside with a substitute, assistant or alternate who is present in the home. Thus a provider may care for eight children only under these limited provisions, which are designed to allow adequate care and attention for the children without penalizing those providers who have young children residing in the home.

These provisions, like most other requirements in the Manual, are enforced through on-site inspections, monitoring visits and complaint investigations by the family day care sponsoring organization. If a provider is found to exceed the maximum number of children in the home, she receives a violation report requiring compliance with the Manual and indicating a reinspection date. In most cases, the provider achieves compliance before the reinspection occurs. These matters rarely come to the attention of the media, and are never referred to law enforcement officials unless criminal activity is suspected.

COMMENT: One commenter objected to the regulation at N.J.A.C. 10:126-6.2(a)11 permitting providers to operate without a telephone in the home under certain conditions.

RESPONSE: The Division disagrees. This regulation is intended to enable low-income providers to become registered when they cannot afford telephone service in the home, but have access to a nearby phone for emergency use. In fact, only a handful of providers without phones in their homes have actually become registered since the rule was initially adopted in 1988, and no problems have been reported in their compliance with this rule. Only a minor revision to this rule is now being adopted.

COMMENT: Two commenters objected to the amendments at N.J.A.C. 10:126-6.5(c) concerning supervision of children using swimming pools or other bodies of water. One commenter suggested that a rule requiring two people to supervise six or more children would be adequate for pools that are at least 24 inches in depth, rather than two people supervising three or more children, as indicated in the amendments. One commenter suggested that the proposed amendments should be clarified to indicate that direct on-site supervision is required for pool use.

RESPONSE: The Division disagrees with the first commenter. These amendments are designed to increase supervision when pools are being used, since most young children cannot swim and can easily drown if supervision is inadequate. The Division agrees with the second commenter and has amended the rule accordingly at N.J.A.C. 10:126-6.5(c)1 and 2.

COMMENT: One commenter suggested that the amendments at N.J.A.C. 10:126-6.18(b), which specify the proportion of the home's operating hours when the provider must be present, would be subject to varying interpretations.

RESPONSE: The Division disagrees. The rule clearly states that the provider must be "scheduled to care for children at least 75 percent of the home's operating hours." Thus, if the home operates 50 hours per week, the provider is required to be scheduled to care for children at least 37.5 hours per week; if the home operates 200 hours per month, the provider is required to be scheduled to care for children at least 150 hours per month. If any questions arise regarding interpretation of the rule in specific cases, the Bureau of Licensing will advise the sponsoring organization and provider of the appropriate application of the rule.

COMMENT: One commenter objected to the proposed amendments at N.J.A.C. 10:126-6.18(e)2 prohibiting persons in the home from smoking within sight of children. The commenter suggested that it would be inappropriate for providers to leave the children unattended long enough to smoke, and that others in the home should not be subjected to this rule.

RESPONSE: The Division disagrees. This amendment was designed to limit children's exposure to second-hand smoke, and to avoid children's observation of adult role models who are smoking. If a provider cannot find an opportunity to smoke out of the children's sight, smoking can be postponed until the children's nap time. Other smokers in the home can easily step into another room or area while smoking, so that the health hazards to children are reduced.

COMMENT: One commenter expressed concern about the amendments at N.J.A.C. 10:126-6.18(h) concerning the release of a child to a person who appears to be impaired. The commenter suggested that this rule is an inappropriate extension of power to the provider. The commenter also objected to the amendment at N.J.A.C. 10:126-6.18(i) requiring the provider to call the Division's Office of Child Abuse Control (OCAC) if he or she is unable to prevent the release of a child to an impaired person. The commenter suggested that this rule penalizes working parents when child abuse has not occurred.

RESPONSE: The Division disagrees. These rules are designed to safeguard children and prevent harm by delineating actions the provider is authorized to take when the parent's condition would endanger the child, as in the case of an intoxicated parent attempting to transport a child. While the Division agrees that the provider cannot forcibly withhold a child from the parent, it is essential that the provider seek assistance to prevent risk to the child's safety. OCAC can arrange for appropriate professional intervention in such cases, even if it determines that the child abuse did not take place.

COMMENT: One commenter questioned the Division's statement that the economic impact of the amendments would be minimal. The commenter suggested that providers who hire assistants and care for the assistant's children for no fee would have to purchase food, equipment and supplies for these children.

RESPONSE: The Division disagrees. The great majority of providers do not employ assistants and would be unaffected by the costs mentioned. While the cost of items for the assistant's child would have an economic impact on certain providers, the rules do not prevent the provider from asking the assistant to supply whatever the assistant's child may need. Although a few other amendments would have an economic impact on some providers, the Division believes that most providers would experience minimal economic impact from the amendments in general.

COMMENT: One commenter questioned the procedures for allowing input by family day care providers into the development of the amendments.

RESPONSE: The amendments were developed by the Division in consultation with a Citizens Ad Hoc Advisory Committee, which met several times in 1992 and 1993. The Advisory Committee consisted of representatives from the State Child Care Advisory Council, the Family Day Care Organization of New Jersey, the New Jersey Family Child Care Providers Association, and the New Jersey Association for the Education of Young Children. At least three committee members are currently registered family day care providers, and several are former providers. In addition, all registered providers were notified of the proposed amendments and given the opportunity to submit comments on them.

COMMENT: The Family Day Care Organization of New Jersey (FDCO-NJ) commented on the proposed amendments at N.J.A.C. 10:126-6.1 concerning the maximum number of children permitted in the family day care home. The organization includes representatives of agencies involved in family day care, including the family day care sponsoring organizations under contract with the Division and several private family day care networks. While the group expressed support for the intent of the amendments, concerns were expressed that they were too lengthy and confusing for many family day care providers to understand and apply.

RESPONSE: The Division agrees and has re-worded and re-codified this section in order to simplify and clarify the rules, without changing the intent or effect of the proposal. The changes to this section being made on adoption have been reviewed and approved by the FDCO-NJ as a necessary improvement to enable family day care providers to understand the rules, so that they can more readily comply with them. While these changes reflect considerable rewriting and reorganization of the proposal, the impact upon the regulated public has not been changed, and all the proposed provisions have been incorporated into the adopted changes. As such, these changes are substantive but do not require re-proposal.

Specifically, at N.J.A.C. 10:126-6.1(a), the phrase "no more than five children" has been changed to read "a maximum of five children" and a citation is corrected to reflect the recodification that follows. At N.J.A.C. 10:126-6.1(b) and (c), the rules concerning children below two years of age are deleted in order to clarify and re-codify them at N.J.A.C. 10:126-6.2. Since these provisions refer to the ages of the children served rather than the overall maximum number of children served, it is helpful to the reader to move them to a separate section from N.J.A.C. 10:126-6.1.

Specifically, the provisions proposed at N.J.A.C. 10:126-6.1(b)1, concerning children below 15 months of age without a second caregiver present in the home, are now addressed at N.J.A.C. 10:126-6.2(a)1i. The provisions proposed at N.J.A.C. 10:126-6.1(b)2, concerning children below two years of age without a second caregiver present in the home, are now addressed at N.J.A.C. 10:126-6.2(a)1ii. The provisions proposed at N.J.A.C. 10:126-6.1(b)3, concerning children between two and six years of age without a second caregiver present in the home, are now addressed at N.J.A.C. 10:126-6.2(a)2. The provisions proposed at N.J.A.C. 10:126-6.1(b)4, concerning children who reside with the provider, alternate provider, substitute provider or provider assistant, are now addressed at N.J.A.C. 10:126-6.2(c). The provisions proposed at N.J.A.C. 10:126-6.1(b)5, concerning children six years of age or older, are now addressed at N.J.A.C. 10:126-6.2(a)3. The provisions proposed at N.J.A.C. 10:126-6.1(c), requiring the presence of both the provider and the alternate provider, substitute provider or provider assistant, are now addressed at N.J.A.C. 10:126-6.2(b).

At N.J.A.C. 10:126-6.1(d), the proposed amendments specifying when a provider is permitted to care for more than five children have been re-worded and re-codified as N.J.A.C. 10:126-6.1(b), without changing the intent or meaning of the proposal. At N.J.A.C. 10:126-6.1(e) and (f), the proposed amendments have been deleted because their provisions are now included elsewhere in this section or the following section. Specifically, the provisions proposed at N.J.A.C. 10:126-6.1(e)1, concerning children who reside in the provider's home, are now addressed at N.J.A.C. 10:126-6.1(b)1. The provisions proposed at N.J.A.C. 10:126-6.1(e)2, setting a total of eight children, are now addressed at 10:126-6.1(b). The provisions proposed at N.J.A.C. 10:126-6.1(e)3, concerning children below two years of age, are now addressed at N.J.A.C. 10:126-6.2. The provisions proposed at N.J.A.C. 10:126-6.1(f), concerning children six years of age or older residing in the provider's home, are now addressed at N.J.A.C. 10:126-6.1(b)1 and 6.2(a)3.

Summary of Agency-Initiated Changes:

The Division has made several technical changes in codification, spelling and punctuation. In addition, the Division has made minor substantive changes in order to clarify the intent of the rules and to use consistent wording in similar rules.

At N.J.A.C. 10:126-1.4(a)3, the phrase "records of compliance" has been changed to read "record of compliance" in order to be consistent with the singular form used in the same phrase at N.J.A.C. 10:126-1.4(b)5. At N.J.A.C. 10:126-1.4(a)5, the phrase "restricted by the requirements of the State Child Abuse and Neglect law" is changed to read "restricted from public access under the requirements of the State

Child Abuse and Neglect Law" in order to be consistent with the wording and capitalization used in the same phrase at N.J.A.C. 10:126-1.4(c)1. At N.J.A.C. 10:126-1.4(b)9, the phrase "restricted by the requirements of the State Child Abuse and Neglect Law or any other State law" is changed to read "restriction from public access under the requirements of the State Child Abuse and Neglect Law or other State law" in order to be consistent with the wording used in the same phrase at N.J.A.C. 10:126-1.4(c)1. At N.J.A.C. 10:126-1.4(c)2, the phrase "restricted from public access under the State Child Abuse and Neglect Law" is changed to read "restricted from public access under the requirements of the State Child Abuse and Neglect Law or other State law" in order to be consistent with the wording used in the same phrase at N.J.A.C. 10:126-1.4(c)1.

At N.J.A.C. 10:126-4.6(a), the spelling of the word "advise" is corrected. At N.J.A.C. 10:126-5.2(c)2, the final semi-colon is changed to a period. At N.J.A.C. 10:126-5.10(b) and (c)10 to 15, citations have been corrected.

At N.J.A.C. 10:126-6.5(c)2 (recodified as N.J.A.C. 10:126-6.6(c)2), a provision has been added to clarify the amendment requiring one person at least 14 years old to supervise all children using a pool less than 24 inches in depth. The new provision indicates that a second caregiver must be present if required under the provisions in N.J.A.C. 10:126-6.1(b)3 or N.J.A.C. 10:126-6.2(b).

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

10:126-1.2 Definitions

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

"Alternate provider" means a person who shares child care responsibilities with a registered provider at the provider's residence and meets all applicable requirements, as specified in N.J.A.C. 10:126-5 and 6.

...

"Chapter" means the rules contained in the Manual of Requirements for Family Day Care Registration, as specified in N.J.A.C. 10:126, which reflect provisions that constitute minimum baseline requirements below which no family day care sponsoring organization or registered family day care provider that is subject to the authority of N.J.S.A. 30:5B-16 et seq. is legally permitted to operate.

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

...

"Family day care home" means the private residence of the family day care provider in which child care services are provided to no fewer than three and no more than five children at any one time for no fewer than 15 hours per week, except that the Division shall not exclude a family day care home with fewer than three children from voluntary registration.

...

"Shall" denotes a provision of this chapter that a sponsoring organization or a family day care provider must meet to qualify for approval or a Certificate of Registration, respectively.

"Should" denotes a recommendation reflecting goals toward which a sponsoring organization or a family day care provider is encouraged to work.

...

"Substitute provider" means a person at least 18 years of age designated by the provider and approved by the sponsoring organization who is readily available to provide child care in the provider's home when the provider cannot be present.

...

10:126-1.4 Public access to records

(a) The Division shall make the following items in its files available for public review:

1. Correspondence between the Division and the sponsoring organization or other parties in matters pertaining to the Division's review and inspection of the sponsoring organization;

2. Inspection/violation reports, where applicable, reflecting results of Division inspections/reinspections of the sponsoring organization or of providers;

3. Forms and other standard documents used to collect routine data on the sponsoring organization and its program as part of its record*[s]* of compliance with the Manual of Requirements;

4. Enforcement letters from the Division requiring abatement of violations of the Manual of Requirements;

5. Completed complaint investigation reports, except for child abuse/neglect investigations or other information restricted *[by]* ***from public access under*** the requirements of the State Child Abuse and Neglect *[law]* ***Law*** or other State law; and

6. Any other documents, materials, reports or correspondence that would normally be included as part of the public record.

(b) The sponsoring organization shall make the following items in its files available for public review:

1. Applications for Certificates of Registration and related materials/documentation;

2. Copies of temporary and regular Certificates of Registration;

3. Correspondence between the sponsoring organization and the provider or other parties in matters pertaining to the sponsoring organization's monitoring or registration of the provider;

4. Evaluation/monitoring reports, where applicable, reflecting the results of the sponsoring organization's evaluation/monitoring of the provider;

5. Forms and other standard documents used to collect routine data on the provider as part of the provider's record of compliance with the Manual of Requirements;

6. Enforcement letters from the sponsoring organization requiring abatement of violations of the Manual of Requirements;

7. Correspondence to the sponsoring organization from the Division regarding enforcement actions against the provider;

8. Chronological lists of events about the provider on compliance/enforcement matters;

9. Completed complaint investigation reports, except for child abuse/neglect investigations or other information restricted *[by]* ***from public access under*** the requirements of the State Child Abuse and Neglect Law or *[any]* other State law; and

10. Any other documents, materials, reports or correspondence that would normally be included as part of the public record.

(c) The Division and the sponsoring organization shall keep confidential and not part of the public record the following:

1. Records, reports or correspondence that pertain to child abuse/neglect investigations that are restricted from public access under the requirements of the State Child Abuse and Neglect Law or other State law;

2. Records, reports, correspondence or forms containing names and/or any other information pertaining to children, parents or providers that are restricted from public access under the ***requirements of the*** State Child Abuse and Neglect Law ***or other State law***;

3. Records, reports, correspondence or forms containing names of enrolled children and/or their parents;

4. Confidential information with regard to specific sponsoring organization personnel;

5. Memoranda and other internal correspondence between and among public agencies, including internal communication between the Division and the Office of the Attorney General;

6. Any items that deal with reports of inspections and/or complaint investigations that are still in progress;

7. Physician's statements and results of Mantoux tests or chest x-rays received from providers, applicants and others, as specified in N.J.A.C. 10:126-5.2(b) and (c);

8. Disclosures of criminal convictions received from providers, applicants and others, as specified in N.J.A.C. 10:126-5.2(a)10; and

9. Other material required by State law to be maintained as confidential.

10:126-2.2 Administrative responsibility

(a)-(g) (No change.)

10:126-2.3 Reporting requirements

(a)-(b) (No change.)

(c) The sponsoring organization shall notify the appropriate regional office of the Division and the Bureau, verbally, of any of the

following changes or events by the next working day after the sponsoring organization learns of their occurrence:

1.-3. (No change.)

4. Any criminal conviction(s) of the staff of the sponsoring organization or of a provider, alternate provider, substitute provider, provider assistant, or member of a provider's household;

5.-6. (No change.)

(d) (No change in text.)

10:126-2.4 Sponsoring organization records

(a) The sponsoring organization shall maintain in files located at its office the following records:

1. (No change.)

2. Records on providers:

i.-ii. (No change.)

iii. Health records received for the provider or applicant and the alternate provider and provider assistant, if any, as specified in N.J.A.C. 10:126-5.2(b) through (d);

iv. Letters of reference received for the provider or applicant and the alternate provider, if any, as specified in N.J.A.C. 10:126-5.2(e);

v. (No change.)

vi. A written report of each visit by the sponsoring organization to the home of the provider or applicant, as specified in N.J.A.C. 10:126-4.1(c)5 and 4.7(d);

vii. A record of pre-service and in-service training sessions completed by the provider or applicant and the alternate provider, if any, as specified in N.J.A.C. 10:126-4.2(f);

viii.-x. (No change.)

(b) The sponsoring organization shall provide to the Bureau upon request:

1. A list of names, addresses and telephone numbers of all registered providers; and

2. Statistical records, including:

i. The number of providers registered; and

ii. The number and ages of the children served.

(c) (No change in text.)

10:126-3.2 Types and responsibilities of staff

(a) Each sponsoring organization shall have an executive director or administrator who is responsible for the overall management and administration of the sponsoring organization's family day care registration program. The executive director or administrator shall designate a person to assume this responsibility in his or her absence.

(b)-(c) (No change.)

(d) The executive director/administrator or designee shall ensure:

1.-8. (No change.)

10:126-4.1 Evaluation of family day care provider applicants

(a)-(b) (No change.)

(c) The sponsoring organization's evaluation of each applicant shall include a review of:

1. (No change.)

2. Disclosures by the provider or applicant, the substitute provider, all members of the provider's household who are at least 14 years old, and the provider assistant and the alternate provider, if any, of any criminal conviction(s), as specified in N.J.A.C. 10:126-5.2(a)10;

3. Letters of reference received for the provider or applicant and the alternate provider, if any, as specified in N.J.A.C. 10:126-5.2(e);

4. Health records submitted by the provider or applicant and by the alternate provider and provider assistant, if any, as specified in N.J.A.C. 10:126-5.2(b) and (c);

5. (No change.)

6. Evidence showing that the applicant and the alternate provider, if any, have completed pre-service training, as specified in N.J.A.C. 10:126-4.2.

(d) (No change.)

(e) The sponsoring organization should encourage and assist providers who do not have a working telephone in the home to secure telephone service.

10:126-4.2 Training of family day care providers

(a) The sponsoring organization shall provide six hours of pre-service training for each provider or applicant and alternate provider prior to the issuance of a regular Certificate of Registration.

(b) (No change.)

(c) The pre-service training session(s) for providers, applicants and alternate providers shall include group or individual instruction provided by persons with expertise in areas listed in (b) above, and may be supplemented by:

1.-3. (No change.)

(d)-(g) (No change.)

(h) The sponsoring organization should encourage providers to attend training in first aid and cardio-pulmonary resuscitation.

10:126-4.6 Complaints and violations

(a) When the sponsoring organization receives a complaint of alleged violation(s) of the Manual of Requirements by a provider, other than child abuse/neglect, the sponsoring organization shall investigate the complaint and shall require the provider to abate any violations found. The sponsoring organization shall *[advice]* ***advise*** complainants that complaints may be made anonymously. The sponsoring organization's investigation shall include a visit to the home whenever such a visit is necessary to substantiate the complaint.

(b)-(d) (No change.)

10:126-4.8 Technical assistance

(a)-(b) (No change.)

(c) The sponsoring organization shall make the following information available to providers:

Recodify existing 2.-5. as 1.-4. (No change in text.)

10:126-5.1 Provider eligibility

(a) A family day care provider, in order to be eligible for a Certificate of Registration, shall:

1.-2. (No change.)

3. Be in sufficient physical, mental and emotional health to care properly for children to be placed in the home;

4. Reside in the family day care home; and

5. (No change in text.)

10:126-5.2 Application for registration

(a) An applicant for an initial or renewal Certificate of Registration shall submit to the sponsoring organization a completed application form, which shall include:

1. (No change.)

2. A statement indicating:

i. The provider applicant, the alternate provider, if any, and the substitute provider are at least 18 years of age; and

ii. The provider assistant, if any, is at least 14 years of age;

3.-4. (No change.)

5. (No change in text.)

6. The name, address and telephone number of the provider assistant and the alternate provider, if any, and the substitute provider;

7. A statement from the provider applicant indicating that all pets are domesticated, free from disease, non-aggressive, and meet all applicable State and local codes or ordinances pertaining to the keeping of pets;

8. An indication as to whether the provider applicant wishes to be listed with either or both of the following:

i. The New Jersey Child Care Resource and Referral System; and

ii. A list of registered providers that is available to the public through the Bureau;

9. A disclosure of information about and circumstances surrounding any previous denial, suspension, revocation or nonrenewal of a Certificate of Registration as a family day care provider in New Jersey or of a license, certificate or other approval as a family day care provider in any other state; and

10. A disclosure of the presence or absence of criminal convictions by the provider applicant, the substitute provider, all members of the provider's household who are at least 14 years old, and the alternate provider and the provider assistant, if any.

i. Evidence of conviction of a crime, in itself, shall not automatically preclude an individual from serving as a provider, provider assistant, alternate provider or substitute provider, and shall not automatically result in denying the application or revoking, suspending or refusing to renew the Certificate of Registration. Such determination shall be made on a case by case basis, in keeping with the provisions of the State Rehabilitated Convicted Offenders Act (N.J.S.A. 2A:168A-1 et seq.) which provides that a person convicted of a crime may not be disqualified or discriminated against by a licensing authority unless the conviction relates adversely to the occupation, trade, vocation, profession or business for which a license is sought.

ii. The provider shall notify the sponsoring organization by the end of the sponsoring organization's next business day of any criminal conviction(s) during the three-year registration period by the provider, the substitute provider, a member of the provider's household who is at least 14 years old, and the alternate provider and the provider assistant, if any.

(b) An applicant for an initial or renewal Certificate of Registration shall also submit to the sponsoring organization a physician's statement(s) for the applicant, the alternate provider and the provider assistant, if any, verifying the applicant, the alternate provider and the provider assistant are in good health, free from communicable disease and able to care for children. Such statement(s) shall be based on a medical examination conducted within the six months immediately preceding the submission of the application.

(c) An applicant for an initial Certificate of Registration shall also submit to the sponsoring organization written proof of the results of either (c)1 or 2 below for the applicant, the alternate provider and the provider assistant, if any:

1. A Mantoux tuberculin skin test with five TU (tuberculin units) of PPD tuberculin, conducted within the six months immediately preceding the submission of the application; or

2. A chest x-ray if the individual has had a previous positive Mantoux tuberculin test or has a medical contraindication that precludes a Mantoux test*[;]**.*

(d) The provider, the alternate provider and the provider assistant shall obtain additional Mantoux tests when required by the Bureau based on a recommendation by the State Department of Health.

(e) An applicant for an initial Certificate of Registration shall also submit to the sponsoring organization one of the following, for both the applicant and the alternate provider, if any:

1. Two letters of reference, dated within three years immediately preceding the submission of the application, including at least one from a person who can attest to the individual's character, reputation and suitability to work with children; or

2. The names, addresses and telephone numbers of at least two persons who can provide letters of reference upon request.

(f) The provider applicant shall permit and participate in an evaluation of the applicant's home by the sponsoring organization. The evaluation shall include:

1. Inspection of all rooms, furniture and equipment in areas designated for use by enrolled children; and

2. Access to all areas not designated for use by enrolled children, to observe whether any hazards to children exist.

(g) The provider applicant and the alternate provider, if any, shall attend six hours of pre-service training provided by the sponsoring organization.

(h) (No change in text.)

10:126-5.3 Issuance of a Certificate of Registration

(a)-(d) (No change.)

(e) If it is necessary to change any information noted on the application, other than a change of residence, after the Certificate of Registration has been issued, the provider shall advise the sponsoring organization in writing no later than 15 calendar days after the change.

(f) If the provider changes residence:

1. The provider shall notify the sponsoring organization by the beginning of the sponsoring organization's next working day, as specified in N.J.A.C. 10:126-5.9(b)5;

2. The Certificate of Registration at the previous residence shall be void;

3. The provider shall submit a new application for registration to the sponsoring organization;

Recodify existing 1.-2. as 4.-5. (No change in text.)

(g)-(h) (No change.)

10:126-5.4 Issuance of a temporary Certificate of Registration

(a) (No change.)

(b) A temporary Certificate of Registration may be issued for a period not to exceed six months. The sponsoring organization may issue as many temporary Certificates of Registration as it deems necessary. However, a provider shall not operate pursuant to temporary Certificates of Registration for more than one year.

10:126-5.6 Renewal of a Certificate of Registration

(a)-(b) (No change.)

(c) No later than 45 days prior to the expiration of the current Certificate of Registration, the provider shall submit to the sponsoring organization:

1. A completed application form, as specified in N.J.A.C. 10:126-5.2(a); and

2. Physician's statement(s) for the provider, the alternate provider and the provider assistant, if any, as specified in N.J.A.C. 10:126-5.2(b).

(d) (No change.)

(e) Prior to the renewal of a Certificate of Registration, the provider shall:

1. Provide documentation of attendance at six hours of in-service training, provided or approved by the sponsoring organization, during the last three-year registration period; or

2. (No change.)

10:126-5.7 Denials, suspensions, revocations, nonrenewals, and provider appeal procedures

(a) The sponsoring organization may deny an application for a Certificate of Registration or suspend, revoke or refuse to renew a Certificate of Registration for good cause, including:

1.-3. (No change.)

4. Refusal to furnish the sponsoring organization or Division with records;

5. Refusal to permit a parent of an enrolled child or an authorized representative of the sponsoring organization or Division to gain admission to the family day care home during normal operating hours; or

6. A determination by the Division's Institutional Abuse Investigation Unit or District Office that children in the home are at risk of harm.

(b) When a provider or applicant is found to be in violation of any of the provisions of (a) above, the sponsoring organization shall notify the provider or applicant of the violation(s) in writing and shall afford the provider or applicant an opportunity to abate the violation(s). If the provider or applicant fails to abate the violation(s), or commits the same or another violation subsequently, the sponsoring organization may deny the application or suspend, revoke or refuse to renew the Certificate of Registration.

(c) When the sponsoring organization proposes to deny an application or to suspend, revoke or refuse to renew a Certificate of Registration, the sponsoring organization shall give written notice to the provider or applicant, specifying the reason for such action, either by hand-delivery or by certified mail with return receipt requested.

1. The notice shall afford the provider or applicant an opportunity for a review before the sponsoring organization's appeals committee, except as specified in (c)2 below.

2. If the action specified in the notice is based on an investigation or substantiation by the Division of alleged child abuse or neglect, or on a criminal conviction, the sponsoring organization's appeals committee shall not review the matter, in keeping with the confidentiality requirements of the State Child Abuse and Neglect Law, N.J.S.A. 9:6-8.10a, and the rules of the Department of Law and Public Safety, as specified in N.J.A.C. 13:59-1.8. In such a case, the notice shall afford the provider or applicant an opportunity to appeal

directly to the Bureau, which will follow the procedures specified in (f) below.

3. The notice shall advise the provider or applicant of the provisions specified in (d) to (g) below.

4. If the provider or applicant does not appeal to either the appeals committee or the Bureau, the action specified in the notice shall take effect.

(d) The sponsoring organization's appeals committee shall review within 15 days each appeal presented to it and shall afford the provider or applicant an opportunity to be heard. The appeals committee shall issue a written report of its findings to the provider or applicant within five working days after completing its review.

(e) If the provider or applicant is not satisfied with the sponsoring organization's appeals committee's findings, the provider or applicant may appeal to the Bureau, which will review the matter and, as appropriate, refer the matter through the Division to the Office of Administrative Law for an administrative hearing pursuant to the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.) and the Uniform Administrative Procedure Rules (N.J.A.C. 1:1).

(f) If the provider or applicant does not want the matter reviewed by the sponsoring organization's appeals committee, or if the action specified in the notice is based on an investigation or substantiation by the Division of alleged child abuse or neglect, or on a criminal conviction, the provider or applicant may appeal directly to the Bureau, which will review the matter and, as appropriate, refer the matter through the Division to the Office of Administrative Law for an administrative hearing.

(g) If the provider or applicant is not satisfied with the decision of the Division, the provider or applicant may appeal the final decision or action of the Division within 45 days from the date of service of the decision or notice of the action taken, to the Appellate Division of the Superior Court of New Jersey.

(h) As long as the Division determines that children are not at risk and no serious or imminent hazards exist, a provider who has requested an appeal, as specified in (d) through (f) above, shall continue to be registered until a final decision is rendered as a result of the appeal.

(i) If the provider's Certificate of Registration is suspended, revoked or refused for renewal, the sponsoring organization shall ensure that the parent of each enrolled child is notified in writing within 10 days of the action.

(j) An applicant whose application has been denied, or a provider whose Certificate of Registration has been revoked or refused for renewal, shall be prohibited from reapplying for registration for one year from the date of the denial, revocation or refusal to renew. After the one-year period has elapsed, the provider or applicant may submit a new application for registration.

10:126-5.8 Special requirements to prevent child abuse and neglect

(a) When the Division determines that an imminent danger or hazard exists that threatens the health or safety of a child in a family day care home, the Bureau may direct the sponsoring organization to deny an application or to suspend, revoke, or refuse to renew a Certificate of Registration immediately.

(b) The Bureau may institute a civil action in a court of competent jurisdiction for injunctive relief to enjoin the operation of a family day care home for good cause, including any imminent danger(s) or hazard(s) that threaten the health and safety of the children in the home.

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

1. The provider or another person in the home has been found by the Division to pose a risk of harm to children;

2. The provider or another person in the home has committed an act of child abuse or neglect, as substantiated by the Division; or

3. The provider or another person in the home has been convicted of an act of child abuse or neglect.

(d) Whenever the Division determines that such corrective action is necessary to protect the children in the home, the sponsoring organization shall ensure that the provider carries out the Division's recommendation for corrective action. Such corrective action may include:

1. Removal or suspension of the affected person from the home, or reassignment to other duties that do not involve contact with the children; or

2. Removal of the affected person from the home for a period of time extending from one hour prior to the arrival of the children until one hour after the children have left; or

3. Suspension of the provider's Certificate of Registration.

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

(f) Substantiation of the child abuse or neglect allegation by the Division shall not, in itself, automatically result in the termination of the affected person from his or her position in the home, or in the denial, suspension, revocation or nonrenewal of the provider's Certificate of Registration, but shall constitute grounds for such action if the person's continued presence in the home would place the children at risk. Such determination shall be made by the Bureau after considering information provided by the provider, the affected person, the sponsoring organization, the Division's Institutional Abuse Investigation Unit and/or District Office, and law enforcement authorities, as applicable and available.

10:126-5.9 Provider reporting requirements

(a) The provider shall verbally notify the Division of Youth and Family Services, Office of Child Abuse Control (toll-free at 1-(800)-792-8610) or District Office immediately whenever there is reasonable cause to believe that a child has been or is being subjected to any kind of child abuse/neglect by any person, pursuant to the State Child Abuse and Neglect Law (N.J.S.A. 9:6-8.9, 8.10, 8.13 and 8.14).

(b) The provider shall report the following incidents to the sponsoring organization as soon as possible, but by no later than the beginning of the sponsoring organization's next working day:

1.-3. (No change.)

4. Any criminal conviction(s) of the provider, the substitute provider, a member of the provider's household who is at least 14 years old, and the alternate provider and the provider assistant, if any, as specified in N.J.A.C. 10:126-5.2(a)10;

5. A change of residence by the provider; and

6. (No change.)

10:126-5.10 Provider record requirements

(a) (No change.)

(b) The provider shall maintain on file a signed statement from each parent, affirming receipt of the Information to Parents statement, as specified in N.J.A.C. 10:126-*[6.12(a)]***6.13(a)***.

(c) The provider shall maintain an individual record for each child in care. This record shall include:

1.-9. (No change.)

10. Results of the health examination for each child, as specified in N.J.A.C. 10:126-*[6.7(a)]***6.8(a)***;

11. An immunization record for each child, as specified in N.J.A.C. 10:126-*[6.7(b)3]***6.8(b)3***;

12. Authorization for a school age child to leave the provider's premises, if applicable, as specified in N.J.A.C. 10:126-*[6.16(b)]* ***6.17(b)***;

13. Authorization for the provider to transport an enrolled child, if applicable, as specified in N.J.A.C. 10:126-*[6.6(b)]***6.7(b)***;

14. Authorization for a child to use a pool or other body of water, if applicable, as specified in N.J.A.C 10:126-*[6.5(d)]***6.6(d)***; and

15. A record of any accidents and injuries sustained by a child, as specified in N.J.A.C. 10:126-*[6.9(d)]***6.10(d)***.

(d)-(e) (No change.)

10:126-6.1 Maximum number of children

(a) The provider shall be permitted to care for *[no more than]* ***a maximum of*** five children at any one time, except as specified in *[(d) to (f)]* ***(b)*** below.

*[(b) When the provider is caring for infants or toddlers below two years of age, without a second caregiver present in the home, the following additional provisions shall apply:

1. The provider shall care for no more than three children below 15 months of age.

2. The provider shall care for no more than four children below two years of age, of whom no more than two children shall be below 15 months of age.

3. When the maximum number of infants or toddlers in (b)1 or 2 above is reached, the provider shall not care for any preschoolers between two and six years of age.

4. All children present who are below six years of age, including those who reside with the provider, alternate provider, substitute provider or provider assistant, shall be included in determining when a second caregiver shall be present.

5. The provider may care for children who are six years of age or older, in addition to the maximum numbers of infants or toddlers specified in (b)1 or 2 above, provided that no more than five children in total are present.

(c) Both the provider and the alternate provider, substitute provider or provider assistant shall be present whenever the provider is caring for more infants or toddlers than the maximum numbers specified in (b) above.

(d) As an exception to (a) above, a provider may care for more than five children when all of the following conditions are met:]*

(b) The provider shall be permitted to care for up to three additional children, up to a maximum of eight children at any one time, only if:

1. The additional children *[shall]* reside with the provider*[, the alternate provider, the substitute provider or the provider assistant;]* ***and are below six years of age. Children six years of age or older who reside with the provider shall not be included in the limit of eight children; or***

2. The additional children *[not residing with the provider shall be served as part of an employment agreement between the provider and]* ***reside with*** the alternate provider, the substitute provider *[and/or]* ***or*** the provider assistant, *[when no payment for the care is being provided;]* ***and receive care in the family day care home for no payment.***

[3. Both the provider and the] ***The*** alternate provider, the substitute provider or the provider assistant shall be present*[; and]* ***when any child who resides with that person is present.***

*[4. No more than eight children in total shall be present.

(e) A provider may care for more than five children, without a second caregiver present in the home, when all of the following conditions are met:

1. The additional children shall reside in the provider's home;

2. No more than eight children in total shall be present; and

3. When infants or toddlers below two years of age are present, the provisions in (b) above shall be met.

(f) Children residing in the provider's home who are six years of age or older shall not be included in the provisions specified in (a) to (e) above.]*

10:126-6.2 Ages of children

(a) When the provider is caring for infants or toddlers below two years of age, without a second caregiver present in the home, the following provisions shall apply:

1. The provider shall be permitted to care for a maximum of either:

i. Three children below 15 months of age; or

ii. Four children below two years of age, of whom no more than two children shall be below 15 months of age.

2. When the maximum number of infants or toddlers specified in (a)1 above is reached, the provider shall not care for any preschoolers between two and six years of age.

3. The provider may care for school-age children who are six years of age or older, in addition to the maximum number of infants or toddlers specified in (a)1 above, provided that no more than five children in total are present. School-age children who reside with the provider shall not be included in the limit of five children.

(b) Both the provider and a second caregiver (either the alternate provider, substitute provider or provider assistant) shall be present whenever the provider is caring for either:

1. More infants or toddlers than the maximum number specified in (a)1 above; or

2. One or more preschoolers along with the maximum number of infants or toddlers specified in (a)1 above.

(c) All children present who are below six years of age, including those who reside with the provider, alternate provider, substitute provider or provider assistant, shall be included in the provisions in (b) above for determining when a second caregiver shall be present.*

10:126-*[6.2]* ***6.3*** Physical environment

(a) The provider shall ensure that:

1.-7. (No change.)

8. Electricity is in service in the home;

9. Rodent and/or insect infestation in the home is controlled;

10. (No change in text.)

11. A working telephone is available in the home. If no working telephone is available in the home:

Recodify existing (1) and (2) as i. and ii. (No change in text.)

iii. (No change in text.)

iv. If the provider must leave the home to use the telephone, the children shall either accompany the provider or be supervised by a person at least 14 years old.

10:126-*[6.3]* ***6.4*** Fire safety

(a) The provider shall have a written plan for the emergency evacuation of the children from the home, which shall be posted in a prominent location when enrolled children are present.

(b) The provider shall ensure that:

1.-2. (No change.)

3. All heating or cooling devices are adequately vented, protected by guards or barriers and kept clear of combustible materials;

4.-7. (No change.)

10:126-*[6.4]* ***6.5*** General safety

(a) The provider shall ensure that:

1. (No change.)

2. All items that may be hazardous to children, including medicines, poisonous plants, toxic substances, tobacco products, matches and sharp objects, are stored out of the reach of children;

3. Safety barriers are installed to prevent children from falling from stairs, ramps, balconies, porches or elevated play areas;

4. All electrical outlets that are accessible to the children have protective covers;

5. A working flashlight is available for emergency lighting; and

6. All firearms, other weapons and ammunition are stored in locked areas out of the reach of children.

10:126-*[6.5]* ***6.6*** Outdoor space

(a) The provider shall ensure that an adequate, safe outdoor play area is available either adjacent to or within walking distance of the home.

(b) Swimming pools, wading pools, hot tubs, whirlpools and natural bodies of water at the family day care home shall be physically inaccessible to children except when they are supervised as specified in (c) below.

(c) The following supervision requirements shall apply whenever enrolled children use a pool or other body of water at the family day care home or any other location:

1. For pools and other bodies of water that are 24 inches or more in depth:

i. One person at least 14 years old shall ***directly*** supervise up to two children.

ii. Two people at least 14 years old shall ***directly*** supervise three or more children.

2. For pools and other bodies of water that are less than 24 inches in depth, one person at least 14 years old shall ***directly*** supervise all the children. ***When the number of children using the pool requires a second caregiver to be present, as specified in N.J.A.C.***

10:126-6.1(b)3 or N.J.A.C. 10:126-6.2(b), both caregivers shall directly supervise the children.*

(d) The provider shall obtain written consent from the parent(s) of each enrolled child before the child uses a pool or other body of water as specified in (c) above.

(e) The provider shall ensure that each child riding a bicycle wears a helmet, as specified in the State Bicycle Helmet Law, N.J.S.A. 39:4-10.1.

10:126-*[6.6]***6.7*** Transportation and trips

(a)-(b) (No change.)

(c) The provider shall ensure that the parents of all enrolled children are informed when their children are taken on walks or trips away from the home.

10:126-*[6.7]***6.8*** Health examinations for children

(No change in text.)

10:126-*[6.8]***6.9*** Sick children

(a)-(b) (No change.)

(c) The provider shall inform the parents of all enrolled children when any person in the home has one of the communicable diseases listed in the chart below:

COMMUNICABLE DISEASES THAT REQUIRE NOTIFICATION TO ALL PARENTS

Respiratory Illnesses	Gastro-intestinal Illnesses	Contact Illnesses
Chicken Pox	Giardia Lamblia	Impetigo
German Measles	Hepatitis A	Lice
Hemophilus Influenzae	Salmonella	Scabies
Measles	Shigella	
Meningococcus		
Mumps		
Strep Throat		
Tuberculosis		
Whooping Cough		

10:126-*[6.9]***6.10*** Accident and injury to a child while in the provider's care

(a) When an accident or injury occurs to a child while in the provider's care, the provider shall take the necessary action to protect the child from further harm and arrange for any necessary emergency medical attention. The provider shall notify the child's parent(s):

1. Immediately in the event of an injury that requires professional medical attention; or

2. By the end of the operating day, if the injury does not require professional medical attention.

(b)-(c) (No change.)

(d) The provider shall maintain on file a record of accidents and injuries sustained by a child while under the provider's care that receive professional medical attention. The record shall include:

1.-3. (No change.)

(e) (No change.)

Recodify existing N.J.A.C. 10:126-6.10 through 6.12 as ***N.J.A.C. 10:126-6.11 through 6.13***. (No change in text.)

10:126-*[6.13]***6.14*** Food and nutrition

(a) (No change.)

(b) The provider shall ensure the provision of:

1.-2. (No change.)

3. Dinner for all children who:

i. to iii. (No change.)

4. (No change in text.)

(c)-(d) (No change.)

Recodify existing N.J.A.C. 10:126-6.14 through 6.17 as ***N.J.A.C. 10:126-6.15 through 6.18***. (No change in text.)

10:126-*[6.18]***6.19*** Supervision

(a) The provider shall be responsible for supervising the children and ensuring their safety at all times. Children who are asleep shall be within hearing and easy access of the provider, alternate provider, provider assistant or substitute provider.

(b) The provider shall be scheduled to care for children at least 75 percent of the home's operating hours. When a provider and an alternate provider share child care responsibilities, the provider shall be scheduled to care for children at least 50 percent of the home's operating hours.

(c) If the provider can not be present, the designated substitute or the alternate provider, if any, as specified in N.J.A.C. 10:126-5.2(a)6, shall assume the provider's responsibility for supervision of the children.

1. The substitute provider and the alternate provider, if any, shall be familiar with all applicable requirements of the Manual of Requirements.

2. When the provider is absent for six or more consecutive weeks and enrolled children continue to receive care in the home, another registered provider or the alternate provider, if any, shall temporarily assume the provider's responsibility for operating the home.

(d) When a provider assistant is present, the provider shall ensure that:

1.-4. (No change.)

(e) No provider nor any other person in the home shall:

1. Consume alcoholic beverages when supervising children or within sight of children; or

2. Smoke within sight of children.

(f) No provider nor any other person shall supervise children when he or she:

1. Has a communicable disease or illness, as specified in the chart in N.J.A.C. 10:126-6.8(c); or

2. Appears to be physically, emotionally or mentally impaired, or appears to have a drug-induced or alcohol-induced condition that would endanger the health, safety or well-being of a child in the home.

(g) (No change in text.)

(h) When a child's parent or person designated by the parent(s), as specified in (g)2 above, appears to be physically, emotionally or mentally impaired, or appears to have a drug-induced or alcohol-induced condition that would endanger the health, safety or well-being of the child, the provider shall:

1. Attempt to prevent the child's release to such an impaired individual; and

2. Attempt to contact the child's other parent or an alternate person authorized by the parent(s).

(i) The provider shall call the Division's Office of Child Abuse Control (toll-free at 1-(800)-792-8610) if:

1. The provider's attempts to prevent the child's release to an impaired person, as specified in (h)1 above, are unsuccessful; or

2. The provider's attempts to make alternative arrangements for the child's care, as specified in (h)2 above, are unsuccessful, and the provider can not continue to care for the child in the home.

10:126-*[6.19]***6.20*** Guidance and discipline

(No change in text.)

10:126-*[6.20]***6.21*** Communicating with parents

(a)-(b) (No change.)

(c) The provider shall inform each child's parent(s) of the names of the provider assistant and the alternate provider, if any, the substitute provider and any other persons caring for children in the home.

(d) The provider shall inform each child's parent(s) upon enrollment about:

1. The presence of pets in the home; and

2. Smoking by any person in the home.

(e)-(f) (No change.)

LABOR

(a)

DIVISION OF WORKERS' COMPENSATION

Notice of Administrative Correction
1995 Maximum Workers' Compensation Benefit Rates
N.J.A.C. 12:235-1.6

Take notice that the Department of Labor has discovered an error in the adopted amended text of N.J.A.C. 12:235-1.6(b) as published in the November 7, 1994 New Jersey Register at 26 N.J.R. 4410(b). As proposed at 26 N.J.R. 3549(b), the year date at the end of subsection (b) was to be changed from 1994 to 1995. However, in the publication of the adoption of this amendment without change, the 1994 date was erroneously retained. That error is corrected through this notice, published pursuant to N.J.A.C. 1:30-2.7.

Full text of the corrected rule follows (addition indicated in boldface **thus**; deletion indicated in brackets [thus]):

12:235-1.6 Maximum workers' compensation benefit rates

(a) (No change.)

(b) This maximum compensation shall be effective as to injuries occurring in the calendar year [1994] **1995**.

LAW AND PUBLIC SAFETY

(b)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF DENTISTRY
Continuing Education
Adopted Amendment: N.J.A.C. 13:30-8.18

Proposed: May 16, 1994 at 26 N.J.R. 1948(a).

Adopted: August 3, 1994 by the State Board of Dentistry, Stephen Candio, D.D.S., President.

Filed: November 22, 1994 as R.1994 d.621, **with substantive and technical changes** not requiring additional public notice and comment. (See N.J.A.C. 1:30-4.3.)

Authority: N.J.S.A. 45:6-10.1 to 10.9 and 45:6-19.4.

Effective Date: December 19, 1994.

Expiration Date: March 12, 1995.

Summary of Public Comments and Agency Responses:

The State Board of Dentistry afforded all interested parties an opportunity to comment on the proposed amendments to N.J.A.C. 13:30-8.18, relating to continuing education. The official comment period ended on June 15, 1994. Announcement of the opportunity to respond to the Board appeared in the New Jersey Register on May 16, 1994 at 26 N.J.R. 1948(a). Announcements also were forwarded to: Newark Star Ledger, Trenton Times, Asbury Park Press, Currier Post, Bergen Record, New Jersey Dental Association, New Jersey Hospital Association, New Jersey Dental Assistant Association, American Dental Hygiene Association, New Jersey Department of Health, and to other interested individuals and organizations.

A full record of this opportunity to be heard can be inspected by contacting the Board of Dentistry, 124 Halsey Street, Newark, New Jersey 07102.

The Board of Dentistry received one comment during the official 30 day comment period from the New Jersey Dental Association.

A summary of the comments received and the Board's responses follows:

COMMENT: The Board should grant hour for hour credit for the program portion of dinner meetings of constituents and components of professional dental associations rather than a maximum of one credit per meeting.

RESPONSE: It is the Board's experience that the program portion of dinner meetings actually dedicated to dental instruction is, with rare exceptions, one hour only. The remainder of time spent at such meetings is usually spent in social interaction. For purposes of uniformity the Board believes that granting a maximum of one credit per meeting as long as the program meets the Board's education requirements makes clear the credit a licensee can expect to receive for attendance at such dinner meetings.

COMMENT: It appears that there was an oversight in the amendment to this rule which allowed credit for meetings of constituents and components of dental professional associations recognized by the Board. Although the Board clearly intended to include meetings of national, state, and local associations, the amendment only included constituents and components which terms refer to state and local associations only.

RESPONSE: The Board acknowledges this oversight and has included in this notice of adoption the specific term "national" in order to clarify that meetings can be approved for credit at national, state, and local levels.

COMMENT: Rather than allowing a maximum of five hours of continuing education credit, the Board should grant one hour of credit for each hour of instruction for all cardiopulmonary resuscitation and emergency cardiac care courses. This subject matter is very important, and hour for hour credit should be granted.

RESPONSE: Although the Board has recognized the importance of CPR courses by allowing a maximum of five credits, it is also the Board's intent that a licensee should take courses in a variety of areas which should include dental and science courses. If the Board allowed hour for hour credit for CPR courses, a licensee theoretically could fulfill the entire continuing education requirement by taking CPR courses only. Certainly licensees are encouraged to take as many courses in CPR training as they feel appropriate for their practice, but only a maximum of five credits will be awarded for such courses in any biennial registration period.

COMMENT: Although the Board has amended this regulation to permit videotape, audiotape and/or correspondence courses, the maximum should be increased from five hours of credit to 10 hours of credit.

RESPONSE: Although the Board determined to amend this rule to permit licensees to achieve continuing education credit through home instruction, the Board believes that a maximum of five hours of continuing education for such courses is more than sufficient. In cases of licensees who have a disability or extreme financial hardship, such licensees may request a waiver of all or a portion of the requirements or permission to take more courses through home study for reasons of hardship such as illness or disability or other good cause.

COMMENT: The Board currently permits four hours of credit annually for each full day or equivalent of a full day per week per academic year for licensees involved in teaching or research activities. Two credits should be granted for licensees who are engaged in such activities ½ day per week.

RESPONSE: The Board believes that half day of such activities per week is too little and too difficult to document. Granting credits for this minimal period would apply then as well to part-time clinical supervisors in various institutional programs which was not the intent of the rule.

COMMENT: Full time faculty members should not be excused from the continuing education requirement. It is just as important for instructors to keep pace with developments in the profession.

RESPONSE: Although full time faculty members are not automatically exempt from the continuing education requirements, the Board continues to believe that such instructors should be eligible for a waiver of all or a portion of the requirements at the Board's discretion in view of the fact that full time faculty appointments involve on-the-job continuing education and continuing research in the field.

COMMENT: The commenter supports the amendments granting waivers to licensees with inactive or retired registrations; including pro-rata credit requirements for licensees who apply for licensure after the commencement of a registration period; reducing the period in which licensees must retain attendance records to four years; permitting carry over of a maximum of seven credits to the subsequent registration period; and eliminating the requirement of three hours of credit in infection control during each registration period.

RESPONSE: Accepted.

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

13:30-8.18 Continuing Dental Education

(a) (No change.)

(b) Any licensee who has no authority to practice dentistry in New Jersey because the licensee holds an inactive registration issued to persons not practicing in this State or a retired registration issued to persons who, for at least 25 years, practiced dentistry in this State and then retired from practice shall be exempt from the continuing education requirements upon biennial renewal of the inactive or retired registration. Any such licensee who desires to resume the practice of dentistry in this State shall be required to certify, as part of the application for an active registration, that he or she has completed 20 hours of continuing education courses for each year of inactive or retired registration retroactive to July 16, 1992 prior to the issuance of an active registration.

(c) Each applicant for a biennial license renewal shall be required to complete, during the preceding biennial period, a minimum of 40 credits of continuing dental education. Any applicant who is initially licensed subsequent to the commencement of any biennial registration period shall be required to complete dental education credits on a pro rata basis prior to the next renewal period in accordance with the following schedule:

1. Licensed October-January in the first year of period ..... 40 credits
2. Licensed February-April in first year of period ..... 35 credits
3. Licensed May-July in first year of period ..... 30 credits
4. Licensed August-October in the first year of period ..... 25 credits
5. Licensed November-January in second year of period ..... 20 credits
6. Licensed February-April in second year of period ..... 15 credits
7. Licensed May-July in second year of period ..... 10 credits
8. Licensed August-October in second year of period ..... Five credits

(d) One hour of continuing education credit shall be granted for each hour of instruction at lectures, seminars, clinical or laboratory participatory courses, meetings of ***national,*** constituent*[s]***,*** and components of dental professional associations recognized by the Board, or other educational methods as may be approved by the Board, excluding time spent at meals, breaks or business sessions. Credit shall be granted only for full instructional hours, but not for less than one instructional hour. Successful completion of an entire course or segment of course instruction is required in order to receive any continuing education credit. Unless otherwise provided, only in class participation, not student time devoted to preparation, will be counted.

(e) It shall be the responsibility of each licensee to maintain an authenticated record of all continuing education activity completed and to be prepared to submit evidence of completion of the credit requirements to the Board upon request. Each licensee must obtain from the continuing education course sponsor and retain for a period of four years an authenticated record of attendance which shall include, at a minimum, the following:

1.-7. (No change.)

(f) (No change in text.)

(g) All continuing education activities to be accepted for credit shall have significant intellectual or practical content which deals primarily with matters directly related to the practice of dentistry or with the professional responsibilities or ethical obligations of licensees. Subjects such as estate planning, financial or investment/tax planning, personal health or others so deemed by the Board from time to time shall not be acceptable for continuing education credit.

(h) A continuing education sponsor may receive prior approval for a course of acceptable subject matter and be assigned a designated number of continuing education credits by the Board if the program sponsor provides, in writing and on a form provided by the Board, information required by the Board to document that the course meets the following requirements:

1.-3. (No change.)

(i) Applications for pre-approval of continuing education programs must be submitted by the program sponsor on the form provided by the Board at least 45 days prior to the date the continuing education program is to be offered. Incomplete applications shall be returned to the sponsor and may result in a failure to grant prior approval of the program. Although failure to obtain prior approval shall not preclude acceptance of the program, there shall be no assurance that the Board will grant approval retroactively.

(j) A licensee may select from any of the areas of study listed below, except that for purposes of obtaining continuing education credits towards the mandatory requirement the licensee may not exceed the maximum number of hours permitted in each category for each biennial period.

1. Educational and scientific courses:

i. A licensee may obtain all of the required continuing education hours in this category.

ii. (No change.)

iii. A maximum of five hours of continuing education shall be given to a student or an instructor for basic C.P.R. courses.

iv. A maximum of five hours of continuing education shall be given for videotape, audiotape and/or correspondence courses. The course must include a written post-test in order to be eligible for credit, and such test shall be retained by the licensee as an additional record of completion of the course.

v. The program portion of dinner meetings of constituents and components of professional dental associations recognized by the Board shall be granted a maximum of one credit per meeting as long as the program meets the educational requirements of (g) above.

2. (No change.)

3. Teaching and research appointments:

i. A licensee involved in teaching or research activities at least one full day or the equivalent of one full day per week per academic year and who holds at least a part time faculty or research appointment shall receive four hours of continuing education credit annually for each full day.

ii. A licensee may obtain a maximum of 20 continuing education credit hours in this category in a biennial period.

4. (No change.)

(k) (No change.)

(l) A maximum of seven continuing education credits completed by a licensee in excess of the requirement as herein provided may be credited to the subsequent registration period.

(m) Any continuing education courses directed or ordered by the Board as a remedial measure shall not be eligible to fulfill the general mandatory continuing education requirement.

(n) The Board may, in its discretion, waive all or a portion of the requirements for continuing dental education on an individual basis for reasons of hardship such as illness or disability or other good cause including, but not limited to, a full time faculty appointment to an accredited dental school or dental hygiene school. Any licensee seeking a waiver of the continuing education requirement must apply to the Board in writing and set forth with specificity the reasons for requesting the waiver. The licensee also shall provide the Board with such additional information as it may reasonably request in support of the application.

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Speed Limits
Rising Sun Square Road-Old York Road
Bordentown Township, Burlington County
Adopted Amendment: N.J.A.C. 16:28-1.181

Proposed: October 3, 1994 at 26 N.J.R. 3934(a).
Adopted: November 14, 1994 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: November 15, 1994 as R.1994 d.605, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-98 and 39:4-198.

Effective Date: December 19, 1994.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

16:28-1.181 Rising Sun Square Road-Old York Road

(a) The rate of speed designated for Rising Sun Square Road-Old York Road (under State jurisdiction) described in this section shall be established and adopted as the maximum legal rate of speed thereat for both directions of traffic:

1. Bordentown Township:

i. Zone 1: 40 miles per hour between the State of New Jersey-Township of Bordentown jurisdictional line and Tennis Court.

ii. Zone 2: 30 miles per hour between Tennis Court and Route U.S. 206.

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping
Route U.S. 9
Middle Township, Cape May County
Adopted Amendment: N.J.A.C. 16:28A-1.7

Proposed: October 3, 1994 at 26 N.J.R. 3935(a).
Adopted: November 14, 1994 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: November 15, 1994 as R.1994 d.602, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-198 and 39:4-199.

Effective Date: December 19, 1994.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

16:28A-1.7 Route U.S. 9

(a)-(b) (No change.)

(c) The certain parts of State highway Route U.S. 9 described in this subsection shall be designated and established as "handicapped parking" areas, where parking is prohibited in spaces appropriately marked for vehicles for the physically handicapped pursuant to N.J.S.A. 39:4-197.5. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following handicapped parking areas:

1. In Cape May County:

i. In Middle Township:

(1) Along the southbound (westerly side):

(A) Beginning at a point 55 feet south of the southerly curb line of Church Street and extending 22 feet southerly therefrom.

(d) The certain parts of State highway Route U.S. 9 described in this subsection shall be designated and established as "time limit parking" zones, where parking is prohibited except as specified. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established time limit parking zones:

1. In Cape May County:

i. In Middle Township:

(1) One hour time limit parking daily, along both sides:

(A) Beginning at the northerly curb line of Steel Road-Hand Avenue (County Road 658) to the southerly curb line and prolongation of the southerly curb line of Church Street.

(e) The certain parts of State highway Route U.S. 9, described in this subsection, shall be designated and established as "loading zones" where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following loading zones:

1. In Cape May County:

i. In Middle Township:

(1) Along the southbound (westerly side):

(A) Beginning at a point 330 feet north of the northerly curb line of Mechanic Street (County Road 615) and extending 50 feet northerly therefrom.

(b)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping
Route U.S. 40
Pilesgrove Township, Salem County
Adopted Amendment: N.J.A.C. 16:28A-1.28

Proposed: October 3, 1994 at 26 N.J.R. 3936(a).
Adopted: November 14, 1994 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: November 15, 1994 as R.1994 d.603, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-198 and 39:4-199.

Effective Date: December 19, 1994.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

16:28A-1.28 Route U.S. 40

(a) The certain parts of State highway Route U.S. 40 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times.

1.-3. (No change.)

4. No stopping or standing in Pilesgrove Township, Salem County:

i. Along both sides between Jill Road and Sharptown-Auburn Road.

ii. Along both sides beginning at a point 400 feet west of East Lake Road and extending to a point 750 feet east of East Lake Road (approximate mileposts 11.60 to 11.80).

5.-9. (No change.)

(b) (No change.)

(c)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping
Route N.J. 47
Middle Township, Cape May County
Adopted Amendment: N.J.A.C. 16:28A-1.33

Proposed: October 3, 1994 at 26 N.J.R. 3936(b).
Adopted: November 14, 1994 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: November 15, 1994 as R.1994 d.604, **without change.**
Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-198 and 39:4-199.
Effective Date: December 19, 1994.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
COMMENT: Norman R. Lochten, Administrator for Middle Township, in a letter to the Department dated October 24, 1994, pointed out that the Economic Impact statement accompanying the proposed amendment at N.J.A.C. 16:28A-1.33 inadvertently indicated that "the local government will bear the costs for the installation of appropriate parking restriction zone signs."
RESPONSE: The Department recognizes the error and advised Mr. Lochten in a letter dated November 14, 1994, that the Department of Transportation will bear the costs for the installation of appropriate parking restriction zone signs.

Full text of the adoption follows:

16:28A-1.33 Route 47
(a) The certain parts of State highway Route 47 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.
1. In Cape May County:
i. In Middle Township:
(1) Along both sides:
(A)-(B) (No change.)
(C) Between Kimbles Beach Road and Hand Avenue (approximate mileposts 10.66 to 10.74).
(2) (No change.)
ii. (No change.)
2.-3. (No change.)
(b)-(e) (No change.)

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Bridge Usage
Route N.J. 47
Middle Township, Cape May County
Adopted Amendment: N.J.A.C. 16:30-9.14

Proposed: October 3, 1994 at 26 N.J.R. 3937(a).
Adopted: November 14, 1994 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: November 15, 1994 as R.1994 d.606, **without change.**
Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-198.
Effective Date: December 19, 1994.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

16:30-9.14 Route 47
(a) The certain parts of State highway Route 47 described in this subsection shall not be used for the purposes described herein. In accordance with N.J.S.A. 39:4-198, authority is granted to erect appropriate signs.
1. No jumping, diving, crabbing, fishing or loitering along both sides of the entire length of the bridge over the waterway listed:
i. Cape May County:
(1) The bridge over Grassy Sound in Lower Township;
(2) The bridge over Bidwells Creek in Middle Township known as Bridge No. 0507-12 (approximate milepost 12.11).

(b)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Turn Prohibitions
Route U.S. 130
Burlington City, Burlington County
Adopted Amendment: N.J.A.C. 16:31-1.22

Proposed: October 3, 1993 at 26 N.J.R. 3938(a).
Adopted: November 14, 1994 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: November 15, 1994 as R.1994 d.608, **without change.**
Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-123, 39:4-124, 39:4-125, 39:4-183.6, 39:4-198 and 39:4-199.1.
Effective Date: December 19, 1994.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

16:31-1.22 Route U.S. 130
(a) Turning movements of traffic on certain parts of State highway Route U.S. 130 described in this subsection are regulated as follows:
1.-4. (No change.)
5. In Burlington City, Burlington County:
i. No left turn:
(1) From northbound on Route U.S. 130 to westbound on Bordentown Street (County Road 657) (approximate milepost 47.45).
(2) From southbound on Route U.S. 130 to eastbound into the driveways of Burlington Billiards (approximate mileposts 47.43 to 47.46).
ii. No "U" turns:
(1) From northbound on Route U.S. 130 to southbound on Route U.S. 130 at Bordentown Street (County Road 657) (approximate milepost 47.45).
(2) From southbound on Route U.S. 130 to northbound on Route U.S. 130 at Bordentown Street (County Road 657) (approximate milepost 47.45).

TREASURY-TAXATION

(c)

DIVISION OF TAXATION
Sales and Use Tax
Sales of Horses in Claiming Races
Adopted Amendment: N.J.A.C. 18:24-28.2

Proposed: October 17, 1994 at 26 N.J.R. 4166(a).
Adopted: November 23, 1994 by Robert K. Thompson, Deputy Director.
Filed: November 23, 1994 as R.1994 d.626, **without change.**
Authority: N.J.S.A. 54:32B-24(1).
Effective Date: December 19, 1994.
Expiration Date: June 4, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

18:24-28.3 Claiming races
(a)-(b) (No change.)
(c) For purposes of computing the sales tax due, if no previous purchases have been made within the calendar year, the full purchase price is subject to sales tax. If previous purchases have been made in the calendar year, the sales tax is imposed only on the portion of the total purchase price that exceeds the highest of any prior purchase prices paid for the same horse within the State in the same calendar year. The sales tax is collected at the track at the time the claim is paid.
Example 1: Horse X is entered in a $10,000 claiming race at Monmouth Park. ABC Farms claims the horse. Horse X has not been previously claimed in the same calendar year. A taxable transaction has taken place and the tax due is $600.00.
Example 2: Same facts as Example 1, but Horse X had previously been claimed twice in the same calendar year for $3,000 and $5,000. A taxable transaction has taken place and the tax due is $300.00 ($10,000 − $5,000 = $5,000; 6% of $5,000 = $300.00).

(a)

DIVISION OF TAXATION

Transfer Inheritance and Estate Tax

Adopted Amendments: N.J.A.C. 18:26-1.1, 2.2, 2.5, 2.12, 2.15, 3.2, 3.7, 3.8, 3.9, 3.10, 6.3, 6.6, 7.7, 7.12, 8.5, 8.6, 8.7, 8.8, 8.17, 8.18, 9.7, 9.13, 9.15, 10.5, 10.7, 11.1, 11.31, 12.2, 12.3, 12.4, 12.5, 12.6, 12.10 and 12.12

Adopted New Rules: N.J.A.C. 18:26-8.7, 10.8 and 10.13

Adopted Repeal: N.J.A.C. 18:26-2.9

Adopted Repeal and New Rules: N.J.A.C. 18:26-8.22 and 12.9

Proposed: October 17, 1994 at 26 N.J.R. 4166(c).
Adopted: November 23, 1994 by Robert K. Thompson, Deputy Director, Division of Taxation.
Filed: November 23, 1994 as R.1994 d.627, **with substantive and technical changes** not requiring additional public notice and comments (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 54:50-1.

Effective Date: December 19, 1994.
Expiration Date: June 4, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Summary of changes between proposal and adoption:
The Division, on its own initiative, has added transition language to N.J.A.C. 18:26-3.2(e) and 8.8(b). N.J.A.C. 18:26-3.2(e) began with the language "No assessment of additional estate tax shall be made after the expiration of more than four years from the date of filing of an estate tax return. ..." N.J.A.C. 18:26-8.8(b) commenced with the language "No assessment of additional inheritance tax shall be made after the expiration of more than four years from the later of the date of the filing of an inheritance tax return or payment of tax due thereon."
The four year statute of limitations is derived from P.L. 1992, c.175 and is effective, under N.J.S.A. 54:48-7, "for tax liabilities accruing on and after the July 1 next following its enactment," i.e., July 1, 1993. In order to follow N.J.S.A. 54:48-7, N.J.A.C. 18:26-3.2(e) is modified as follows: "For estates with date of death on or after July 1, 1993, no assessment of additional estate tax shall be made . . ." Similarly, N.J.A.C. 18:26-8.8(b) is modified as follows: "For estates with date of death on or after July 1, 1993, no assessment of additional inheritance tax shall be made. . ." The taxes accrue on the date of death under N.J.S.A. 54:38-5. The modifications therefore bring the rule into closer conformity with N.J.S.A. 54:48-7 and N.J.S.A. 54:38-5.
A misprint in N.J.A.C. 18:26-3.9(c) is corrected. In N.J.A.C. 18:26-3.9(c) the word "interests," plural, should be "interest," singular.

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

18:26-1.1 Definitions
The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.
. . .
"Blanket waiver" means the general written consent of the Director issued by regulation permitting banks, trust companies, savings institutions, building and loan and savings and loan associations operating in this State, to transfer up to 50 percent of any shares held for or of the total funds on deposit to the credit of a deceased resident of this State, either individually as a co-depositor, trustee, agent, cestui que trust, or in any other capacity, prior to the final payment of the tax and in the absence of a formal waiver. The blanket waiver also authorizes the release of an amount in addition to the said 50 percent, called for by a check or checks made payable to the New Jersey Inheritance Tax Branch, in payment of transfer inheritance taxes chargeable.
. . .

18:26-2.2 Law at the time of death controls
The right of the State to the inheritance tax on transfers vests at the moment of a decedent's death so that the law prevailing at the time of death of a resident or nonresident controls the transfers subject to the tax and the rates thereon.

18:26-2.5 Rates for Class "A" transferree
Recodify existing (b)-(g) as (a)-(f) (No change in text.)

18:26-2.9 (Reserved)

18:26-2.12 Renunciation or disclaimer
(a) (No change.)
(b) A copy of the disclaimer or renunciation should be filed with the Transfer Inheritance Tax Branch.

18:26-2.15 Bond in lieu of payment
(a) (No change.)
(b) Upon the happening of the contingency or condition to which a transfer is subject, the executor, administrator, trustee or other proper representative shall notify the Transfer Inheritance Tax Branch of the date the occurrence took place and a computation of the tax due shall then be made. (See N.J.A.C. 18:26-9.16).
(c) (No change.)

18:26-3.2 Amount and nature of tax
(a)-(d) (No change.)
(e) *[No]* ***For estates with date of death on or after July 1, 1993, no*** assessment of additional estate tax shall be made after the expiration of more than four years from the date of filing of an estate tax return except in the following cases:
1. The return is false or fraudulent with the intent to evade tax;
2. If before the expiration of the four year period prescribed in this subsection for the assessment of additional tax a taxpayer consents in writing that such period may be extended, the amount of such additional tax may be determined at any time within such period. The period so extended may be further extended by subsequent consents in writing made before the expiration of the extended period;
3. An additional or increased estate tax becomes payable as a result of a redetermination, or additional or corrected assessment of estate, inheritance, succession, or legacy taxes by the United States government or any state or territory of the United States, including the District of Columbia. (See N.J.A.C. 18:26-3.4 for requirement to notify the Division of a redetermination of estate tax by the Internal Revenue Service.); or

4. The Federal estate tax chargeable on final assessment has not been definitely determined.

(f) The taxes assessed pursuant to (e)3 and 4 above shall be made within four years from the date the additional or increased estate tax becomes payable or the Federal estate tax chargeable on final assessment is definitely determined and the Branch is properly notified pursuant to N.J.A.C. 18:26-3.4.

Statutory Reference
N.J.S.A. 54:38-1; 54:49-6(b)

18:26-3.7 Payment; due date; interest; extension of time

(a) The New Jersey estate tax is due at the date of a decedent's death. However, if payment is made within nine months from the date of death, no late penalty shall be imposed.

(b) All or any part of the estate tax due this State, if not paid within nine months from the date of death, shall bear interest at the rate of 10 percent per annum from the expiration of the said nine months until the date of actual payment, unless an extension of time to file the Federal estate tax return is granted, in which case the Director may reduce the interest rate to six percent per annum until the expiration of the extension. If the decedent was a member of the United States armed forces, the estate tax will not bear interest until the expiration of nine months after receipt of official notification of the decedent's death by the decedent's husband, wife, father, mother, or next of kin. (For estates with date of death prior to March 1, 1992, the estate tax is payable within 18 months of the date of death, and estate tax not paid within 18 months from the date of death bears interest at the rate of six percent per annum from the expiration of the 18 months until the date of actual payment. If the Federal government has not determined the amount of estate tax due within such period of 18 months or there is a subsequent assessment of an additional or increased estate tax, the tax is payable within 60 days after receipt of notification from the Federal government stating the amount of the Federal estate tax and the credit for state death taxes allowable and the New Jersey estate tax shall bear interest at the rate of six percent per annum from the expiration of such 60 day period to the date of payment.)

Recodify existing (b)-(d) as (c)-(e) (No change in text.)

18:26-3.8 Certificate of inheritance

(a)-(b) (No change.)

(c) Proof of such payments can be submitted to the Internal Revenue Service after receipt by the estate of notice of final assessment, and allowance will be made at that time for credits properly established. The Transfer Inheritance Tax Branch will use best efforts to expedite estate tax assessments.

18:26-3.9 Refunds

(a)-(b) (No change.)

(c) For estate tax paid with respect to reports or returns due on or after January 1, 1994, interest will be paid on overpayments not refunded within six months after the last date prescribed, or permitted by extension of time, for filing the return, or within six months after the return is filed, or payment of the tax due thereon, whichever is later. See N.J.A.C. 18:26-10.13 for calculation of the interest*[s]*.

Statutory Reference
N.J.S.A. 54:38-3; 54:49-15.1

18:26-3.10 Protests, hearings and appeals

Any executor, administrator, trustee, person or corporation liable for the payment of the estate tax and aggrieved by any decision, order, finding or assessment of the Director, may appeal to the Tax Court of New Jersey for a review thereof within 90 days of the date of notice assessing the tax complained of, in accordance with pertinent provisions of the State Tax Uniform Procedure Law, N.J.S.A. 54:51A-13 et seq. For protest procedures see N.J.A.C. 18:26-12.9, 12.10 and 12.12.

18:26-6.3 Dower or curtesy

(a) In the case of an estate of a resident decedent dying, prior to May 28, 1980, intestate and seized of real property who is survived by a spouse and a child or children, the interest of the spouse in the real property by way of dower or curtesy provided under N.J.S.A. 3A:35-1 and 2 is not subject to the inheritance tax of this State; provided, however, that such spouse takes only his or her dower curtesy interest in the real property or has such interest set off or admeasured by way of election under the will or otherwise.

(b) (No change.)

(c) In the case of a resident decedent dying on or after May 28, 1980, there is no exemption for the interest of the spouse in real property by way of dower or curtesy unless both the real estate was purchased and the marriage took place prior to May 28, 1980.

Statutory Reference
N.J.S.A. 3A:25-1; 3A:35-2; 3B:28-2

18:26-6.6 Wrongful death action

Any sum recovered under Sections 1, 2, 3 and 4 of the New Jersey Death Act (N.J.S.A. 2A:31-1 et seq.) as compensation for wrongful death of a decedent is not subject to the New Jersey inheritance tax except as provided in N.J.A.C. 18:26-5.3(a).

18:26-7.7 Estates subject to escheat

Estates subject to escheat containing claims for services rendered to the decedent or advances made to the decedent are held in abeyance pending a final determination made with respect thereto by the Attorney General's Office, Escheat Section. The representatives of the estate will be so notified.

18:26-7.12 Real estate broker's commissions

(a) No deduction is allowed for commissions paid or payable to a real estate broker or agent in connection with the sale of real estate of which a decedent dies seized except where:

1. (No change.)

2. The real estate is actually sold by the executor or administrator (the real estate must be sold by the representative of an estate and not the beneficiary(s) in order to qualify); or

3. It is necessary in the administration of the decedent's estate to effect a sale of said real estate for the purpose of liquidating debts, or the payment of the expenses of administration of the estate, or for the payment of legacies.

18:26-8.5 Additional assessment

Recodify (b) and (c) as (a) and (b) (No change in text.)

18:26-8.6 Final assessment

N.J.S.A. 54:34-12 provides for an assessment of the tax by the Division. Upon receipt of the return and payment of any applicable tax, the Transfer Inheritance Tax Branch will advise the estate representative as to whether the return filed by the estate and the tax calculation are accepted, in which case the Branch's notification will be the assessment. In the event that the Branch decides to further examine the return, it will subsequently notify the estate representative as to the amount of tax assessed.

18:26-8.7 Assessment notices; required statements

(a) Any assessment notice changing the tax as reported by the taxpayer shall contain the statements required pursuant to subsections a, b, and d of N.J.S.A. 54:48-6.

(b) An arbitrary assessment of tax made pursuant to the provisions of N.J.S.A. 54:49-5 shall include a statement of the reason for the assessment, the action or omissions of the taxpayer which require the assessment, or the nature of the documentary evidence, if any, which has prompted the assessment, including the following:

1. In the case of an underpayment or failure of payment, a statement of the corresponding alleged correct payment and the correct date of payment; and

2. In the case of a failure to file a return, a statement of the alleged filing date.

(c) The lack of any statement otherwise required to be included with a notice pursuant to (a) above, or the lack of any description otherwise required pursuant to (b) above, shall not invalidate such notice.

Statutory Reference
N.J.S.A. 54:50-6

18:26-8.8 Time limit for assessment

(a) Upon the expiration of a period of 15 years after the date of death of a decedent, no proceeding may be instituted to assess or collect any tax, interest or penalties due this State for Inheritance Tax purposes against any estate, executor, administrator, trustee, grantee, donee, vendee, devisee, legatee, heir, next of kin or beneficiary. However, this does not affect any rights to collection which this State has by reason of filing with the Clerk of the Superior Court, a Certificate of Debt, Decree of Judgment for the New Jersey Inheritance Tax, including any interest and penalties; nor does the period of limitation affect the rights of this State to assess and collect the New Jersey Inheritance Tax including any interest and penalties under the terms of a bond or their agreement securing the payment of such tax, interest and penalties.

(b) *[No]* ***For estates with date of death on or after July 1, 1993, no*** assessment of additional inheritance tax shall be made after the expiration of more than four years from the later of the date of the filing of an inheritance tax return or payment of tax due thereon. However, the assessment period may be extended in the following cases;

1. The return is false or fraudulent with the intent to evade tax:

2. If, before the expiration of the period prescribed in the subsection for the assessment of additional tax a taxpayer consents in writing that such period may be extended, the amount of such additional tax may be determined at any time within such period. The period so extended may be further extended by subsequent consents in writing made before the expiration of the extended period;

3. Tax on executory devises, contingent future interests and estates subject to a power of appointment is assessed pursuant to the provisions of N.J.A.C. 18:26-8.12, 8.21, 8.24 and 9.16;

4. If the inheritance tax return is amended by the taxpayer to include additional property of a decedent, the assessment of tax on the additional property shall not be made after four years from the date of the filing of the amended return;

5. The assessment of tax in an estate passing to a beneficiary discovered after the filing of an inheritance tax return shall not be made after four years from the date of the discovery of the beneficiary and receipt of notification by the Inheritance Tax Branch; or

6. If a decedent's interest in property, or the value thereof as of the decedent's date of death, has not been determined at the time of the filing of an inheritance tax return due to litigation or controversy, the assessment of tax shall be made within four years after the decedent's interest in the property, or the value thereof on the decedent's date of death, has been definitely established.

(c) Returns not falling into the six categories in (b) above shall be subject to the provisions of (a) above.

(d) For the purposes of (b) above, an inheritance tax return filed before the corresponding day of the eighth month following the decedent's date of death shall be considered as filed on that day.

Statutory Reference

N.J.S.A. 54:35-5.1, as amended by P.L. 1979, c.417; 54:49-6(b)

18:26-8.17 Government bonds and securities

(a) Treasury bonds and similar negotiable obligations issued by the United States Government are valued at:

1. (No change.)

2. If there were no sales of bonds or similar negotiable obligations issued by the United States Government on the date of death, either the mean between the highest and lowest selling price for the previous day, or the nearest trading day prior to the date of death, or the prorated value used for Federal estate tax purposes reflecting the mean between the highest and lowest selling price on the nearest trading dates prior to and subsequent to the date of death may be used. The Alternative Valuation Date method of valuing bonds for Federal estate tax purposes is, however, not acceptable for New Jersey transfer inheritance tax purposes. All of the assets must be valued using the same method;

3. (No change in text.)

(b)-(c) (No change.)

18:26-8.18 Stocks, bonds, mutual funds and securities

(a) The value of stocks, bonds and securities listed on any stock exchange is appraised on the basis of the intermediate price between the low and high price prevailing on the date of death.

1. If there were no sales of stocks, bonds, and securities listed on a stock exchange on the date of death, either the mean between the highest and lowest selling price for the previous day, or the nearest trading day prior to the date of death, or the prorated value used for Federal estate tax purposes reflecting the mean between the highest and lowest selling price on the nearest trading dates prior to and subsequent to the date of death may be used. The Alternative Valuation Date method of valuing stocks and bonds for Federal estate tax purposes is, however, not applicable for New Jersey transfer inheritance tax purposes. All of the assets must be valued using the same method;

2. (No change in text.)

(b)-(d) (No change.)

18:26-8.22 Estates for life or years

A life estate, annuity, or estate for a term of years is valued in accordance with the Federal Tables, effective after December 31, 1970, Table "A"(1) (single life male, six percent, showing the present worth of an annuity, of a life interest, and of a remainder interest) and Table "A"(2) (single life female, six percent, showing the present worth of an annuity, of a life interest, and of a remainder interest). These tables are identified as the United States Life Tables in N.J.S.A. 54:36-2. These tables apply as well in cases where a beneficiary survives the decedent by only a short period.

Statutory Reference

N.J.S.A. 54:36-2

18:26-9.7 Confidential nature of returns

(a) All transfer inheritance tax returns and data filed in connection therewith are considered privileged communications pursuant to N.J.S.A. 54:33-8 and 54:50-8 and are not to be inspected or copied by any person other than:

1.-3. (No change.)

4. Photostatic copies of records on file with the Transfer Inheritance Tax Branch may be obtained by authorized persons only upon proper application. Cost of photostatic copies shall be $.40 per page and check in payment thereof shall be drawn to the order of Treasurer, State of New Jersey. Authentication will cost $1.00 in addition to the charge per page.

18:26-9.13 Late payment; general provisions

(a) Any payment of the New Jersey inheritance tax after the expiration of the corresponding day of the eighth month following the date on which it became due and payable shall bear interest at the rate of 10 percent per annum on any unpaid portion of the tax, from the expiration of eight months after the date on which it became due and payable until the date of actual payment, unless payment was tendered by the taxpayer within the eight month period and is evidenced by the postmark of the United States Postal Service on the letter conveying the payment, by a postmark made by other than the United States Postal Service (that is, metered mail) within the eight month period and the payment was received by the Inheritance Tax Branch within three days of the expiration of the eight month period, or by other acceptable proof, but was not credited through no fault of the taxpayer, in which case no interest shall be charged, or unless by reason of any claims made upon the estate, necessary court litigation, or other unavoidable cause of delay, the decedent's estate or a part thereof, cannot be settled before the expiration of eight months from the date of death, in which event interest at the rate of only six percent per annum is to be charged from the expiration of eight months until the cause of delay is removed.

(b)-(d) (No change.)

(e) Tax on any sum recovered as compensation for the death of a person caused by a wrongful act, neglect, or default must be paid within 30 days of the receipt of the award or settlement. Tax not

paid within 30 days shall bear interest at the rate of 10 percent per annum from the expiration of eight months after the due date (the date of the award settlement) to the date of actual payment subject to the exceptions in (a) above.

(f) For returns due on or after July 1, 1993 the Director shall waive the payment of any part of any penalty or interest attributable to the executor's, administrator's, or trustee's reasonable reliance on erroneous advice furnished to the taxpayer in writing on or after July 1, 1993 by an employee of the Transfer Inheritance and Estate Tax Branch acting in the employee's official capacity, provided that the penalty or interest did not result from the failure of the executor, administrator or trustee to provide adequate or accurate information. The executor, administrator, or trustee has the affirmative obligation to show that it was reasonable to rely on the written advice.

Statutory Reference

(a) N.J.S.A. 54:35-3; (e) N.J.S.A. 54:35-4.1; (f) N.J.S.A. 54:49-11(b)

18:26-9.15 Bond for failure to pay tax

(a) Where an executor, administrator, grantee, donee, vendee, or trustee fails to pay the tax due within eight months from the date of a decedent's death, such person is required to give a bond, on a form approved by the Director, to the State of New Jersey, in double the amount of the tax to secure payment of any tax and interest which may become due.

(b) In the case of tax due on any sum recovered as compensation for the death of a person caused by a wrongful act, neglect, or default, the bond shall be required within eight months of the due date (the date of the award or settlement) if the tax is not paid within 30 days of the receipt of the award or settlement.

Statutory Reference

N.J.S.A. 54:35-3, 54:35-4, 54:35-4.1, 54:35-5.

18:26-10.5 Payment of tax collected; receipt

Within 30 days from the time an executor, administrator, or trustee has retained or received the amount due for inheritance taxes on the transfer of property, he is required to pay the same to the Director and may, upon written request, receive a receipt signed by the State Treasurer and countersigned by the Director, which represents a voucher in settlement of the account of the executor, administrator, or trustee.

18:26-10.7 Proceedings to compel payment of taxes; collection cost fees

(a) In the event the New Jersey Transfer Inheritance Tax which has accrued is not paid within the time provided by law, the Director shall notify the Attorney General of this State who shall institute an action to compel the payment of such tax in the name of the Director in the Superior Court of this State and any judgment cited in such action will have the same effect as other judgments entered in the Superior Court so as to constitute a lien which may be executed on any property of a decedent.

(b) In the event the New Jersey inheritance tax is not paid within the time prescribed by law, fees for the cost of collection shall be imposed as follows:

1. If a certificate of debt is issued pursuant to N.J.S.A. 54:49-12, the fee shall be five percent of the tax or $100.00, whichever is greater;

2. If the tax remains unpaid after the issuance of the certificate of debt and the matter is referred to the Attorney General, the fee shall be 10 percent of the tax or $200.00, whichever is greater; and

3. If a suit is instituted for the collection of the tax, the fee shall be 20 percent of the tax or $500.00, whichever is greater.

(c) The fees specified in (b) above shall be paid in addition to any interest or penalty, or both, otherwise provided by law.

Statutory Reference

N.J.S.A. 54:35-15, 54:49-12.1

18:26-10.13 Interest on refunds

If the Inheritance Tax Branch takes more than six months to remit a valid refund after a refund application or written request is received by the Director, taxpayers have the right to receive interest on the refund. If interest must be paid, it will be calculated to accrue from the date of filing of a refund claim, the date of tax is paid in accordance with N.J.A.C. 18:26-8.6, or the due date of the return, whichever is later. Interest will be paid at a rate determined by the Director to be equal to the prime rate, determined for each month or fraction thereof, compounded annually at the end of each calendar year, from the date that such interest commences to accrue to the date of the refund. This rule becomes effective for returns due on and after January 1, 1994. No interest will be paid on an overpayment of less than one dollar ($1.00), or on an overpayment refunded within six months after the last date prescribed or permitted by extension of time for filing the return, or within six months after the return is filed, whichever is later. No interest will be paid on an overpayment unless the taxpayer files a claim for refund.

Statutory Reference

N.J.S.A. 54:49-15.1

18:26-11.1 Consent to transfer; generally

(a)-(b) (No change.)

(c) No waivers are required to be issued by the Director in the case of certain transfers to the surviving spouse of a New Jersey domiciled decedent who died on or after January 1, 1985. In order to satisfy a corporation (its transfer agent) including any banking institution, trust company organized under the laws of New Jersey, national bank operating in this State, building and loan or savings and loan association in New Jersey, or credit union chartered by the United States operating in this State that intangible assets may be released to the surviving spouse, an affidavit of waiver can be executed by the surviving spouse or the personal representative of the decedent's estate.

1. If two or more executors or administrators qualify, the affidavit may be executed by one of them.

2.-5. (No change.)

(d) No waivers are required to be issued by the Director in case of certain transfers to the following Class "A" transferees in the estate of New Jersey domiciled decedent who died on or after July 1, 1988: a father, mother, grandparent, grandchild, a child or children of a decedent, including any stepchild of a decedent or child or children adopted by a decedent or the issue of any child or legally adopted child of a decedent. In order to satisfy a corporation (its transfer agent) including any banking institution, trust company organized under the laws of New Jersey, national bank operating in this State, building and loan or savings and loan association in New Jersey, or credit union chartered by the United States operating in this State that intangible assets may be released to the Class "A" transferee, an affidavit of waiver can be executed by the Class "A" transferee or the personal representative of the decedent's estate.

1. If two or more executors or administrators qualify, the affidavit may be executed by one of them.

2.-5. (No change.)

(e) (No change.)

18:26-11.31 Notice

(a) The notice required by N.J.A.C. 18:26-11.30 is to be given by mailing Form 0-71 to the Division of Taxation, Transfer Inheritance Tax Branch, Trenton, New Jersey 08646 as soon as practicable after the death of the decedent, but in any event not later than 10 days after the whole or any part of the sum or sums required to be reported therein have been paid.

(b) (No change.)

18:26-12.2 Administration of Transfer Inheritance Tax and New Jersey Estate Tax

(a) The Act is administered by the Director through the Transfer Inheritance Tax Branch of the Division of Taxation in the Department of the Treasury.

1.-3. (No change.)

18:26-12.3 Information from Transfer Inheritance Tax Branch

(a) After a return has been filed all communications regarding the New Jersey transfer inheritance or estate tax are to be addressed to the Transfer Inheritance Tax Branch, CN 249, Trenton, New Jersey 08646 and should state the full name of the decedent, the date of death, and the name of the county where the decedent resided as of the date of death. See N.J.A.C. 18:26-9.7 for confiden-

tial nature of communications with the Transfer Inheritance Tax Branch.

(b) (No change.)

(c) No employee of the Transfer Inheritance Tax Branch is permitted to pass upon, or decide, any question involving the taxability of a transfer of any property under the terms of a decedent's will, deed of trust, annuity contract, agreement, contract or any other instrument prior to the date of a decedent's death, nor may an employee compute any hypothetical tax on any set of facts submitted for consideration.

18:26-12.4 Examination of records

For the purpose of administering the New Jersey inheritance and estate tax, the Director, whenever he deems expedient, may make or cause to be made through the Transfer Inheritance Tax Branch or any employee thereof engaged in the administration of such taxes, an examination or investigation of any tangible personal property and any books, records, papers, vouchers, accounts, and documents of any taxpayer. See N.J.A.C. 18:26-12.6 for power of the Transfer Inheritance Tax Branch to issue subpoenas and interview witnesses.

18:26-12.5 Hearings

The Director or his duly authorized employees in the Transfer Inheritance Tax Branch may conduct hearings, subpoena documents, administer oaths to, and examine under oath, any taxpayer as well as any directors, officers, agents and employees of a taxpayer in respect to any matter evident to the administration of the New Jersey Inheritance and Estate Tax.

18:26-12.6 Issuance of subpoenas

The Director, or his duly authorized employees in the Transfer Inheritance Tax Branch, may by subpoena compel the attendance of witnesses and/or the production of any books, records, papers, vouchers, accounts or documents of any taxpayer or of any person who the Director has reason to believe has information pertinent to any matter under investigation by the Director or any such deputy at any hearing held pursuant to law. The fees of witnesses required to attend any such hearing are to be the same as those allowed to witnesses appearing in the Superior Court and shall be paid in the manner provided for the payment of other expenses incident to the administration of the New Jersey transfer inheritance tax or estate tax law.

18:26-12.9 Review

(a) In order to make a protest of a Transfer Inheritance and Estate Tax Branch assessment or finding within the 90 day period provided by N.J.S.A. 54:49-18, a written protest must be submitted to the Branch. The written protest must be signed by the estate representative, certified to be true, and contain the following data:

1. Whether a hearing or a review is requested;

2. The decedent's name, date of death, social security number, and county of residence;

3. The name, address, and telephone number of the estate representative the Branch should contact in connection with the protest;

4. A copy of the assessment or determination subject to the protest;

5. The specific amount of tax or interest under protest;

6. An explanation of the basis for the protest; and

7. The specific facts supporting the basis for the protest and a summary of evidence or documentation to be presented in support of the estate's position.

(b) A submission which does not include the information requested in (a)5 and 6 above will not be considered a valid protest and will not result in a hearing or review. In addition, the submission of an incomplete or invalid protest will not toll or otherwise extend the 90 day period for such protests to the Division of Taxation.

(c) The filing of any valid protest shall stay the right of the Director to collect the tax in any manner provided by law if the estate shall furnish security, within 90 days after the final determination, of the kind and in the amount determined as follows:

1. Security will not be required for amounts in controversy of less than $10,000, except in cases of arbitrary assessments under N.J.S.A. 54:49-5 or 54:49-7. Security may be required in contested amounts of $10,000 or more if it is determined that there is substantial risk that the estate will fail or be unable to pay a liability. In determining whether there is substantial risk of the estate's failure or inability to pay, the Division may consider the following:

i. The taxpayer's record of compliance;

ii. The estate's financial condition; and

iii. Any other information which the Director reasonably believes to be relevant to this determination.

(d) Hearings are scheduled whenever possible by telephone on a mutually acceptable date for both the estate representative and the Branch.

(e) When an application for a refund is made within three years from the date of payment of the tax, the period in which a protest may be submitted is 90 days after a denial of the refund is made.

(e) After the hearing or review of a protest is completed, the Branch will make a final determination confirming, modifying, or vacating the assessment, finding, or denial of a refund request. The estate representative will be notified of the Branch's determination by registered or certified mail. The estate has 90 days after the issuance of the final determination to appeal therefrom to the Tax Court.

Statutory Reference
N.J.S.A. 54:34-13, 54:38-10, 54:49-18

18:26-12.10 Informal hearing

(a) An executor, administrator, trustee, or other interested party may, at any time, request an informal conference with the Transfer Inheritance Tax Branch in order to present information or discuss any issues.

(b) A conference before the Transfer Inheritance Tax Branch may be conducted on an informal basis with or without representation on behalf of a taxpayer or other party in interest.

(c) An estate representative shall be provided, before or during a conference, an explanation of the audit process and the estate's rights under the audit process in the case of a conference relating to the determination of inheritance or estate tax, and shall be provided an explanation of the collection process and the estate's rights under the collection process in the case of a conference relating to the collection of inheritance or estate tax.

(d) Estate representatives have the right, upon giving 14 days advance notice to the Branch, to make a recording of any hearings or conferences with their own equipment and at their own expense; provided, however, that the Branch shall have the same right of recording.

Statutory Reference
N.J.S.A. 54:50-2.2, 54:50-3, 54:1-16, 54:1-17

18:26-12.12 Appeal to Tax Court

(a) Any person aggrieved by any decision, order, finding or assessment of the Director or his deputies, through the Transfer Inheritance Tax Branch, may appeal therefrom to the Tax Court within 90 days from the date a final determination is made. No such appeal shall stay the collection of the tax or the enforcement of the same by entry of judgment unless security, if required pursuant to the standards and subject to the exception of subsection b of N.J.S.A. 54:49-18, approved by the Director of the Division of Taxation has been furnished to the Director of the Division of Taxation.

(b) A prevailing estate in a court proceeding in connection with the determination, collection, or refund of inheritance or estate tax, penalty, or interest may be awarded a judgment or settlement for reasonable litigation costs as set forth in N.J.S.A. 54:51A-22.

Statutory Reference
N.J.S.A. 54:33-2, 54:51A-15, 54:51A-22

INSURANCE

(a)

DIVISION OF ADMINISTRATION

Notice of Administrative Correction
Medical Fee Schedules: Automobile Insurance Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage
Application of Medical Fee Schedules
N.J.A.C. 11:3-29.4

Take notice that the Department of Insurance has discovered an error in the text of N.J.A.C. 11:3-29.4(a) as adopted in the November 21, 1994 New Jersey Register at 26 N.J.R. 4616(b). Referring to certain inpatient services, the third sentence phrase "reimbursement to which shall be limited to" should grammatically read "reimbursement of which shall be limited to." This notice of administrative correction is published pursuant to N.J.A.C. 1:30-2.7.

Full text of the corrected rule follows (addition indicated in boldface **thus**; deletion indicated in brackets [thus]):

11:3-29.4 Application of Medical Fee Schedules

(a) Every policy of automobile insurance and motor bus insurance issued in this State shall provide that the automobile insurer's limit of liability for medically necessary expenses payable under PIP coverage, and the motor bus insurer's limit of liability for medically necessary expenses payable under medical expense benefits coverage, is the fee set forth in this subchapter. Nothing in this subchapter shall, however, compel the PIP insurer or a motor bus insurer to pay more for any service or equipment than the provider's usual, customary and reasonable fee, even if such fee is well below the automobile insurer's or motor bus insurer's limit of liability as set forth in the fee schedules. N.J.A.C. 11:3-29.6 shall not apply to inpatient services provided by acute care hospitals, trauma centers, rehabilitation facilities, other specialized hospitals, residential alcohol treatment facilities and nursing homes, reimbursement [to] **of** which shall be limited to the provider's usual, customary and reasonable fees. Insurers will not be required to pay for services or equipment which are not medically necessary.

(b)-(i) (No change.)

(b)

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program
Adopted Amendments: N.J.A.C. 11:20 Appendix Exhibits A through F
Adopted New Rules: N.J.A.C. 11:20 Appendix Exhibits M, N, O and P

Proposed: July 6, 1994 in accordance with N.J.S.A. 17B:27A-16.1, at 26 N.J.R. 3356(b).

Adopted: November 16, 1994 by the New Jersey Individual Health Coverage Program Board, Kevin O'Leary, Executive Director.

Filed: November 17, 1994 as R.1994 d.614, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17B:27A-2 et seq.

Effective Date: November 17, 1994.

Operative Date: January 1, 1995.

Expiration Date: August 13, 1998.

These amended rules and new rules were proposed and are being adopted pursuant to the procedures set forth in N.J.A.C. 17B:27A-16.1, as therein authorized. Accordingly, notice of the proposal was published in three newspapers of general circulation in New Jersey, and mailed to all known interested parties when submitted to the Office of Administrative Law ("OAL") for publication in the New Jersey Register. Upon expiration of a 20-day public comment period following the publication of notice of the proposal, the Board adopted the amended proposal. The Board is required by law to respond to any comments received within a reasonable period following the adoption of the proposal and to submit the Board's responses to the OAL for publication in the New Jersey Register. That report appears below.

Comments were received from the following:

Paul S. Bunkin
HIP Health Plans of New Jersey
Blue Cross and Blue Shield of New Jersey, Inc.
Washington National Insurance Company

Summary of Hearing Officer Recommendations and Agency Responses:

A public hearing was held before the IHC Board on July 21, 1994 from 10:00 A.M. until 11:02 A.M. There were no commenters at the public hearing. A transcript of the hearing is on file with the IHC Board. Those interested in reviewing the transcript may contact: Wardell Sanders, IHC Board, 20 West State Street, 10th Floor, CN 325, Trenton, New Jersey 08625.

Summary of Public Comments and Agency Responses:

Paul Bunkin

COMMENT 1: The commenter recommended amending the individual health coverage plans to make them portable outside the State of New Jersey.

RESPONSE: The comment suggests a substantive change that goes beyond the scope of the proposal and, likely beyond the Board's statutory authority. Therefore, the Board is not amending the individual health coverage plans as suggested.

COMMENT 2: The commenter suggested that persons covered by group coverage that is more expensive than coverage available in the individual market be allowed to purchase the less expensive individual coverage.

RESPONSE: Again, the commenter suggests a change that goes beyond the scope of the original proposal. Moreover, the Individual Health Insurance Reform Act, N.J.S.A. 17B:27A-2 et seq., conditions eligibility on not being covered by or eligible for the same or similar group coverage. Thus, persons with group coverage are prohibited by statute from obtaining certain individual policies. Additionally, the Board has adopted rules concerning movement between dissimilar group and individual health benefits plans. See N.J.A.C. 11:20-12. As a result, the Board is not making any changes in response to the comment.

Washington National Insurance Company

COMMENT 3: The commenter asked the Board to consider an alternate approach to the proposed amendments to the "Coordination of Benefits" section of the policy forms which amendments would rename the section to "Benefits From Other Plans" and would institute other changes. The commenter proposed adopting a new standard of eligibility for individual plans that is similar to the current eligibility test applicable to persons who have group coverage. Specifically, the commenter suggested that persons eligible for individual coverage that is the same or similar to coverage under a standard health benefits plan be deemed ineligible to purchase a standard health benefits plan. The commenter further cited the value of the approach suggested above by questioning how the proposed "Benefits From Other Plans" section could be administered efficiently by a carrier.

RESPONSE: The Board agrees with the commenter that the administration of the proposed changes to the "Coordination of Benefits" section could be problematic. Therefore, it has decided not to adopt any of the proposed changes to the "Coordination of Benefits" section of the standard policy forms. However, in an effort to further ease the administration of this provision, the Board intends to propose new changes to the "Coordination of Benefits" section along the lines of the commenter's suggestion. Since the contemplated changes are substantive changes from the original proposal, the Board intends to propose these changes in a separate filing.

HIP Health Plans of New Jersey

COMMENT 4: The commenter noted that in the "General Provisions" section of the standard health maintenance organization ("HMO") plan, in Exhibit F, the last two sentences of the "Non-Compliance with

Medically Necessary and Appropriate Treatment" section are not entirely clear.

RESPONSE: The Board does not agree that the last two sentences are unclear. These sentences of the section provide an HMO member, seeking to terminate coverage, with a transition period within which time the member can seek alternate coverage. This transition period runs until the date of termination or within 30 days of notice of the termination, whichever comes first. During the transition, the HMO must cooperate with the member in facilitating a transfer of care. Further, the HMO must continue to provide covered services and supplies in accordance with the terms and conditions of the HMO Contract and the conclusions reached through the Grievance Procedure.

COMMENT 5: The commenter stated that autologous bone marrow transplants and associated highdose chemotherapy is inappropriate treatment for aplastic anemia and genetic disorders. The commenter explained that the conditions in question are characterized by either a failure or deficiency in one's own bone marrow, hence the reason why the aforementioned treatment is not appropriate. The commenter recommended that the standard health benefits be modified to reflect this.

RESPONSE: The commenter is correct. The inclusion of aplastic anemia and genetic disorders within a list of conditions for which autologous bone marrow transplant and associated highdose chemotherapy would be covered was inadvertent. Therefore, the adoption reflects that only allogenic bone marrow transplant coverage will be provided for these conditions.

COMMENT 6: The commenter suggested eliminating the phrase "we are required by law to recognize" as used within the definitions of "Facility" and "Practitioner" in the "Definitions" section of the HMO policy form in Exhibit F. The commenter explained that while the phrase is suited to indemnity policies, it is not meaningful to many HMOs.

RESPONSE: The Board agrees with the commenter and has made the suggested change.

COMMENT 7: To the term "Home Health Agency" in the "Definitions" section of the HMO policy form in Exhibit F, the commenter recommended insertion of the words "or reduce" between the word "eliminate" in the third line and the word "Hospital" in the fourth line.

RESPONSE: The recommended change would expand a Home Health Agency to include those Providers providing care which, while not eliminating Hospital stays, would reduce such stays. This change would conform with the Board's understanding of a Home Health Agency. As a result, the Board is making the suggested change.

COMMENT 8: To the term "Maintenance Drug" in the "Definitions" section of the HMO policy form, the commenter proposed deleting the phrase "the following" in the second line and inserting the phrase "including but not limited to" after "conditions" in that line.

RESPONSE: The list of the common maintenance drugs in the definition was meant to provide examples rather than to be a complete listing of all maintenance drugs. Therefore, the Board has made the suggested change.

COMMENT 9: The commenter suggested that the definition of "Medical Emergencies" in the HMO policy form be made consistent with or at least refer to the later section describing medical emergencies in subsection f. of the "Covered Services and Supplies" section.

RESPONSE: The Board agrees with the comment and has made the two sections in Exhibit F more consistent.

COMMENT 10: The commenter requested that the HMO policy form be changed to use the terms "Contract, Contractholder and Contract Term" instead of "Policy, Policyholder and Policy Term." The commenter stated that the recommended terms are traditionally the terms used by HMOs.

RESPONSE: The Board agrees with the commenter and has made changes accordingly.

COMMENT 11: The commenter suggested deleting the phrase "recognized" from the definition of "Provider" in the "Definitions" section of the HMO policy form in Exhibit F as the phrase is more suited to indemnity policies and is not meaningful to many HMOs.

RESPONSE: The Board agrees with the comment and has made changes accordingly.

COMMENT 12: The commenter requested that the definition of "Specialist Services" include at least some Obstetrician/Gynecologist services.

RESPONSE: The Board has not made the suggested change. Obstetricians and Gynecologists are included within the definition of "Primary Care Physician" and "Specialist Practitioner." These definitions were crafted with some variability to allow for differences among HMOs as to whether or not an Obstetrician or Gynecologist is designated as a Primary Care Physician. Some HMOs choose to include Obstetricians and Gynecologists as Primary Care Physicians for certain services and some do not. The definitions of "Specialist Practitioner" and "Primary Care Physician" were designed with enough variability to allow an HMO to clearly distinguish how it plans to treat obstetrical and gynecological services.

COMMENT 13: The commenter suggested deleting the phrase "we will recognize it" from the definitions of "Home Health Agency," "Mental Health Center" and "Substance Abuse Center" in the HMO policy form explaining that the current language is not meaningful for HMOs.

RESPONSE: The Board agrees and has made the suggested changes.

COMMENT 14: The commenter expressed a concern regarding the difficulty of distinguishing between costs attributable to pregnancy and costs attributable to complications of pregnancy. The commenter noted that the distinction will cause administrative difficulties.

RESPONSE: While the Board understands the concern expressed by the commenter, it has adopted the proposal without change. The Board believes that coverage for complications of pregnancy is an important benefit. For guidance on what constitutes a complication of pregnancy, the commenter should review N.J.A.C. 11:1-4.3.

COMMENT 15: The commenter suggested modifying the "Who is Eligible" paragraph in the "Eligibility" section of the HMO policy form to account for the fact that an HMO can only count those persons who reside in the HMO's service area as eligible.

RESPONSE: The Board agrees with the comment and has made the appropriate changes.

COMMENT 16: The commenter recommended repeating the "Copayment" heading after the section describing "Facility Benefits" in the "Schedule of Benefits" section of the HMO policy form for the sake of clarity.

RESPONSE: The Board agrees with the comment and has made the appropriate change.

COMMENT 17: The commenter questioned the deletion of the late payments penalty in "Payments of Premiums—Grace Period" of the "Premium Rates and Provisions" section of the HMO policy form. The commenter indicated that deletion of the penalty provision could be construed as a toleration of or encouragement of late payments.

RESPONSE: As a clarification to the commenter, the Board has not deleted the penalty provision, but rather has made the provision variable. The Board disagrees that the deletion of the penalty provision necessarily would be construed as a toleration of or encouragement of late payments. As a result, the Board has not made any changes. Nevertheless, if a carrier chooses not to delete the penalty provision, it need not do so since the provision is variable.

COMMENT 18: The commenter questioned why the word "provider" is used in subsection (c) of the "Covered Services and Supplies" section instead of "practitioner."

RESPONSE: The use of "provider" was an error. The Board has replaced the word "practitioner" with "provider."

COMMENT 19: With respect to the "Exclusions" section, the commenter noted that routine eye examinations seem to be excluded and asks that more coverage be provided as a worthwhile preventive benefit.

RESPONSE: This comment is beyond the scope of the original proposal as no change in the eye examination exclusion was proposed. Thus, the Board has made no changes at this time. The commenter should note that currently certain basic eye examinations are covered. See "Covered Services and Supplies."

COMMENT 20: The commenter remarked that the exclusion of services and supplies provided in a government hospital in the "Exclusions" section appears confusing because the exclusion later says such services and supplies are not excluded if they are required to be covered by law.

RESPONSE: This comment is beyond the scope of the original proposal as no change was made to this section in the proposal. The exclusion was drafted to recognize that often government hospitals do not charge for their services. However, the last sentence clarifies that if the law requires reimbursement by the HMO for the services and supplies provided by a government hospital, then the HMO must provide such reimbursement. The Board has not made any changes to the provision upon adoption.

COMMENT 21: The commenter stated that most HMOs typically do not cover vision therapy or TMJ syndrome. The commenter suggested the exclusions for these items be retained in the HMO plan and not deleted as in the proposed regulations.

RESPONSE: The Board has not amended the HMO policy form as suggested. While the exclusions for coverage for TMJ and vision therapy are removed, coverage is subject to all the applicable terms and conditions of the standard HMO plan, that is, coverage is provided only when it is medically necessary and appropriate.

COMMENT 22: In the "Right to Recovery—Third Party Liability" section, the commenter suggested deleting the third paragraph. The commenter remarked that this provision is not typical of HMO contracts at the present time. The commenter further stated that the proposed provision will encourage attempts to label payments differently to avoid paying HMOs to satisfy HMO liens on third party recoveries.

RESPONSE: The Board disagrees with the comments and has not made the suggested change. The Board believes the this provision of the "Right to Recovery—Third Party Liability" section is drafted in accordance with the manner in which judgments are rendered in New Jersey and with the collateral source rule. The Board is not convinced by the argument that the language as it appears in the proposal may influence courts in the manner in which judgments are rendered.

COMMENT 23: With respect to the "Confidentiality" provision in the "General Provisions" section, the commenter suggested restructuring the phrase in the fourth and fifth sentence, "or as may otherwise be provided by law," by moving it to the next to the last line of that same paragraph between the words "us" and "may" for the sake of clarity.

RESPONSE: The Board agrees and has made the suggested change.

COMMENT 24: With respect to the "Incontestability of the Policy" section, the commenter suggested rewording portions of the section to more accurately relate to an HMO delivery system. The suggestion was to change "a loss incurred" to "for benefits." Also, the commenter suggested changing the word "insurance" to "coverage or health coverage."

RESPONSE: The Board agrees and has made the recommended changes.

COMMENT 25: The commenter recommended expanding the Termination of Contract provision to include the following: "(f) Abuse of the system including, but not limited to theft, damage to our Participating Provider's property, forgery of drug prescriptions, and consistent failure to keep appointments; or (g) After reasonable efforts, We or Participating Providers are unable to establish and maintain a satisfactory relationship with the Member or the Member fails to abide by our rules and regulations, or the Member acts in a manner that is verbally or physically abusive."

RESPONSE: The Board addressed this issue but could not conclude whether such language would be appropriate. As a result of its discussions regarding this matter, the Board is and will be looking at both staff model and other HMO arrangements to determine if the suggested change is necessary. At the conclusion of its review, the Board will consider making the changes. As a result, no change has been made at this time.

Blue Cross and Blue Shield of New Jersey

COMMENT 26: The commenter suggested rewording the definitions of "Hospice," "Hospital," "Mental Health Centers" and "Substance Abuse Centers" appearing in the "Definitions" sections in Exhibits A through E of the Appendix to N.J.A.C. 11:20 so as to conform with the definition of "Facility." The commenter specifically suggested recognition of the aforementioned facilities if they are "licensed, certified or accredited by the state in which it operates." The commenter noted that restricting licensure and accreditation to the State of New Jersey is perhaps too narrow and inadvertently makes some state hospices, hospitals, mental health centers and substance abuse centers ineligible under the standard individual policy forms. The commenter further suggested that the definitions of "Rehabilitation Center," "Skilled Nursing Center" and "Surgical Center" also be amended in this fashion.

RESPONSE: The Board agrees and has made the suggested changes.

COMMENT 27: The commenter noted that the definition of "Hospital Admission Review" in the "Definitions" section of the policy forms makes a reference to a nonexistent section of the policies and should be corrected to reference the "Utilization Review Section."

RESPONSE: The Board agrees and has made the suggested changes.

COMMENT 28: The commenter suggested that the standard individual policy forms consistently refer to the defined terms "Mental **or** Nervous Condition" and "Medically Necessary and Appropriate."

RESPONSE: The Board agrees, and for the sake of consistency and clarity, has adopted the suggested changes.

COMMENT 29: The commenter suggested adding the wording "We will not pay for any charges incurred for or in connection with:" as the second sentence of the "Exclusions" section of the HMO policy form in Exhibit F.

RESPONSE: The Board disagrees and believes that the change is inappropriate for the HMO policy form. HMOs do not pay charges, but rather provide services and supplies. As a result, the Board has not made the suggested change.

COMMENT 30: With respect to "Exclusions" section of the HMO policy form, the commenter recommended that the "Pre-existing Condition Limitation" provision should be changed to conform with Plans A through E so that the limitation is waived only with respect to prior group or individual coverage that is "delivered or issued for delivery in the United States."

RESPONSE: N.J.A.C. 11:21-7.8(b) provides that credit towards preexisting conditions limitations for prior coverage is limited to coverages delivered or issued for delivery in the United States. Therefore, the commenter's suggested change is required by existing regulations, and the Board has made the suggested change.

COMMENT 31: With respect to the "Exclusions" sections of policy forms B through E, the commenter suggested that the words "including bony impacted teeth" should be deleted from the "Extraction of teeth" exclusion. The proposed changes had included the extraction of bony impacted teeth as a benefit under policy forms B through E.

RESPONSE: In the rule proposal, the Board added coverage for "the surgical removal of bony impacted teeth" in the "Charges Covered With Special Limitations" section of policy forms B through E, but failed to remove the same language in the "Exclusions" section of policy forms B through E. However, both the rule proposal and the Summary section of the rule proposal noted the changes contemplated by the Board. Since the affected community should reasonably have been aware of the proposed changes, and failure to make the suggested change would result in an internal conflict in the policy forms, the Board has made the suggested changes.

COMMENT 32: The commenter remarked that an exclusion appeared to have been added to the HMO policy form in the "Exclusions" section which would have excluded coverage for services or supplies due to an Accidental Injury or Illness. The commenter asked whether or not this was intentional.

RESPONSE: The Board agrees with the commenter. The addition to the list of excluded services of a service or supply due to an "Accidental Injury or Illness" in the proposal was unintentional. The Board never intended to add this to the list of exclusions. In fact, the addition of exclusions for services or supplies due to Accidental Injury or Illness would conflict with many other provisions in the policy forms. Since the Board did not intend to make this change in the proposal and is making no change in this regard from the original policy form, it has removed the exclusion for "Accidental Injury or Illness" from the HMO policy form's Exclusion section.

COMMENT 33: The commenter noted that the Board's decision to provide certain coverage outside the United States for a dependent attending an accredited school in a foreign country needed to be considered for its impact on provision in the "Exclusions" section of the policy forms for services and supplies provided in an locale outside of the United States.

RESPONSE: The Board has made changes to the "Exclusions" sections of the policy forms to reflect the impact on those sections from the changes which provide coverage outside of the United States.

COMMENT 34: The commenter recommended that the Board adopt a standard form to be used as part of the "Right to Recovery—Third Party Liability" provision that is being added to the standard policy forms.

RESPONSE: The Board believes that such a form might be useful and will consider proposing such a form at a later date.

COMMENT 35: A commenter suggested adding "Health Service Corporations" to the definition of "Other Valid Coverage" within what was originally termed the "Benefits from Other Plans" sections of the standard policy forms. In addition, the commenter questioned how the reduction in premium provision of the "Benefits From Other Plans" section would be administered.

RESPONSE: The Board has decided not to adopt any changes to the "Benefits From Other Plans" sections of the standard policy forms at this time. That section will remain as originally adopted for now. The Board decided not to adopt changes to this section based on the commenter's points about the problems of administering this section with

the proposed changes. The Board agrees that this section, as proposed, could result in administrative difficulties. Moreover, the Board has sought legal advice from counsel on the issue of coordination of benefits. Based on the comment received and advice from counsel, the Board developed another method of addressing problems associated with the coordination of benefits, which method was set forth in a rule proposal published elsewhere in this issue of the New Jersey Register.

COMMENT 36: To the proposed new sections entitled "Alternate Treatment" to policy forms A through E, the commenter recommended that the phrase "or in completing a course of care outside of the acute hospital setting, for example, completing a course of IV antibiotics at home[.]" be added to the end of the sentence of letter a. of the first paragraph.

RESPONSE: The addition of the phrase "or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home" would clarify that Alternative Treatment need not be in the acute hospital setting so long as it is medically necessary and appropriate and determined by the carrier to be cost effective. Since the suggested change does clarify the term Alternative Treatment, the Board has made the suggested change.

COMMENT 37: With respect to policy forms A through E, the commenter asked generally for additional variability to be established to permit the use of managed care terminology.

RESPONSE: The Board recognizes that some of the terminology used in policy forms A through E is inapplicable or inaccurate when used in the context of a managed care delivery system. The use of these terms could cause confusion to consumers. Therefore, the Board has added variability to policy forms A through E to allow for a more complete integration of managed care terminology. The use of managed care terms does not, however, affect the benefits in the policy forms.

COMMENT 38: The commenter requested that the definition of "Policy" in the "Definitions" sections of policy forms A through E, and the definition of "Contract" in the HMO policy form, be amended to include the subscriber's ID card as part of the documents which, collectively, comprise the policy or contract. The commenter also asked that the "Policy Term" section of the policy form cover pages be made variable to accommodate a carrier which does not customize each subscriber's policy form.

RESPONSE: The Board accepts the requests and has added variability to the policy forms.

COMMENT 39: The commenter suggested that all references throughout the policy forms to "he" and "his" be amended to include "she" and "her" respectively.

RESPONSE: The Board intended to make these changes in the proposal and has made changes to the policy forms where the changes were inadvertently not made.

COMMENT 40: The commenter remarked that the word "admission" is not a defined term and, therefore, should not be capitalized throughout the policy forms.

RESPONSE: "Admission" is a defined term in the policy forms. Therefore, the Board has made no changes.

COMMENT 41: The commenter noted that a "Limitation of Actions" section appears twice within each of the policy forms. The commenter suggested deleting one of the sections.

RESPONSE: A "Limitation of Actions" section appears in the "General Provisions" sections and the "Claims Procedure" sections of the policy forms. However, the Board believes it is useful to leave the "Limitation of Actions" section in both sections. As a result, it has not made any changes.

COMMENT 42: To the "Benefit Deductibles and Coinsurance" sections of policy forms A through E, the commenter suggested adding wording to the "Deductible Credit" provision to clarify that such a credit is only available where the subscriber has not suffered an intervening lapse in coverage.

RESPONSE: The suggested change would clarify that certain Deductible Credit is received provided that there has been no lapse in coverage between the previous coverage and the policy. This clarification reflects the intent of the Board and also reflects, to the Board's knowledge, the manner in which the policy forms have been administered to date. The clarification provides consumers with a clear notice that the deductible credit described in the policy forms will not be received if there has been a lapse in coverage. The Board never intended to provide credit to persons who had had their coverage lapse.

COMMENT 43: The commenter asked that the "Premium Rates and Provisions" sections of policy forms A through E be made variable.

RESPONSE: Presumably, the carrier wanted more variability to the "Premium Rates and Provisions" sections to enable the rates to be produced as part of a separate page that becomes attached to the Policy. The Board has added the requested variability.

COMMENT 44: The commenter requested that the POS provisions be amended so as to permit the carrier to require that it must be contacted, in addition to the Primary Care Physician, within 48 hours of a medical emergency.

RESPONSE: The Board accepts that a carrier can require one phone call to either a Primary Care Physician or another designated entity, but the Board does not believe that requiring an insured to make two separate phone calls in a medical emergency is reasonable. Some variability has been added to this section to allow a carrier to define where the emergency call is received. However, the variability only permits a carrier to require one call.

COMMENT 45: The commenter recommended that the 24 hour time frame that appears in the "Continued confinement" provision in "Step 2" of the "Utilization Review" section of policy forms A through E be added to the POS language.

RESPONSE: The optional POS language may used in conjunction with the standard policy forms. Since the "Continued Confinement" provision is already part of the policy forms, it need not be repeated in the POS language. Therefore, the Board has not made the suggested changes.

COMMENT 46: To second sentence of the "Schedule of Benefits" sections of policy forms A through E, the commenter suggested adding the words "unless otherwise stated" after [a]ll benefits subject to unlimited lifetime maximum."

RESPONSE: Since some of the benefits in the "Schedule of Benefits" section are limited, the addition of the phrase "unless otherwise stated" as suggested will provide consumers with some warning that not all benefits are subject to an unlimited lifetime maximum. The suggested change clarifies the benefits under the plans and, as a result, the Board has made the suggested change.

COMMENT 47: To policy forms B through E, the commenter recommended that references to "psychologist or social worker" should be removed from the second paragraph of the Mental or Nervous Conditions and Substance Abuse provision for clarity and consistency.

RESPONSE: The Board agrees with the comment and has made the suggested changes. The Board has moved to the use of a word "Practitioner" in a conscious effort to stop listing specific types of providers within the policy forms.

COMMENT 48: The commenter noted that the "Who is Eligible" section of the HMO Contract should be amended to refer to "same or similar coverage" under both the "Policyholder" and "Child" categories.

RESPONSE: The Individual Health Coverage Act, at N.J.S.A. 17B:27A-3c, provides that for a person to be eligible for individual coverage they must not be covered by or eligible for same or similar group coverage. The commenter's suggested change would make the policy forms more accurate and consistent with applicable law. Therefore, the Board has made the suggested changes.

COMMENT 49: The commenter observed that the HMO contract consistently should refer to "Substance Abuse" and not use the phrase "chemical dependency."

RESPONSE: Since "Substance Abuse" is a defined term within the HMO contract, the Board has changed all references of "chemical dependency" to "Substance Abuse."

COMMENT 50: The commenter noted that some text in the "Schedule of Benefits" section of policy form C was missing.

RESPONSE: The error was caught prior to publication in the New Jersey Register. No additional correction is needed.

All of the changes noted above are primarily for purposes of consistency and clarity. Given that nature, changes are not too substantive, they do not require reproposal.

Summary of Agency-Initiated Changes:

1. In Exhibits A through F, general correction changes have been made as follows: to correct misspellings, to correct punctuation, to capitalize the first letter of defined terms, to use lower case letters for undefined terms unless appropriate for punctuation, and to add quotation marks around words referencing a particular plan provision. Some of these non-substantive changes have been made in this adoption to sections which were published in the rule proposal at 26 N.J.R. 3356, while other non-substantive changes have been made upon adoption to sections of the policy forms not part of the rule proposal.

2. In Exhibits A through F, changes were made to the "Table of Contents" to reflect changes that had or are being made in the policy forms.

3. In the "Definitions" sections of Exhibits A through E, the Board has made the following changes:

(a) In the introductory paragraph, the last sentence which reads "Information about your benefits begins on page 22," brackets have been placed around the "22" to indicate this is a variable based on the printed text of the policy form.

(b) In the definition of "Allowance," the bracket at the end of the first paragraph is being deleted because it belongs at the end of the last paragraph. A closing bracket is added at the end of the second paragraph.

(c) The terms "In-Network Provider" and "Out-of-Network Provider" are being added and the terms "Network Provider" and "Non-Network Provider" are being deleted to make the policy form terminology more consistent with the terminology in the alternative PPO and POS terminology set forth in Exhibits M through P, these changes are also necessary in the "General Provisions" section of Exhibits A through E.

4. In Exhibits A through E, in the "Types of Coverage" part of the "Eligibility" section, the word "Coverage" has been added to follow "Husband and Wife" to make the terminology consistent with the other Types of Coverage.

5. In Exhibits A, C, D and E, "Premium Rates and Provisions" section, the last sentence of the last paragraph, an "s" has been added to the word "Premium" and the words "Rate Changes" added so that the reference is to the "Policy Premiums Rate Changes" provision.

6. In Exhibits A, B and E, in the "Benefit Deductibles and Coinsurance" section, under "Cash Deductibles," the language "(subject to the Family Deductible Cap as described below)" has been added to clarify the meaning of the sentence and provide for consistent language in all plans.

7. In Exhibits A, B, D and E, the "Benefit Deductibles and Coinsurance" section, under "Coinsurance Cap," paragraph three, the "/" is being deleted and replaced with "or" for grammatical reasons and to provide consistent language in all the policy forms.

8. In Exhibits A through E, in the "Covered Charges" section, the provisions for "Practitioner Charges for Nonsurgical Care and Treatment" and "Practitioner Charges for Surgery" are deleted and reinserted to place them in alphabetical order in the list of Covered Charges.

9. In Exhibits A, B, D and E, in "Step 2" of the "Utilization Review" sections, the last sentence of the fourth paragraph, the phrase "[Make No Payment]" is being deleted as the brackets were intended to indicate a deletion in the proposal to make the sentence consistent with the originally proposed change from making no payment to reducing payment by 50 percent.

10. In Exhibits A through E, in the alternative section "Centers of Excellence," in the last sentence, the phrase "the Utilization Review Features" has been changed to read "the requirements of the 'Utilization Review' section" for clarity.

11. In Exhibits A through E, in the "exlcusions" section, the following changes are made:

(a) "Artificial and surgical drugs and procedures" has been reworded to correctly reflect the exclusion for "Artificial drugs and surgical procedures" designed to enhance fertility, etc.

(b) "Services and supplies provided by a social worker, except as otherwise stated in this Policy" was deleted to provide consistency with the plan designs to not specifically enumerate which Practitioners had to provide covered services. As a result, there are no references to social workers left in the Plan.

12. In Exhibits A, B, C, D and E, in the "Benefit Deductibles and Coinsurance" section, the provision entitled "Benefits from other Plans" has not been removed as was proposed. The provision was being removed due to changes proposed in the "Coordination of Benefits" section; however, since no changes are being made to the "Coordination of Benefits" section, the provision needs to remain.

13. Based on comments from the Attorney General's Office, the Board has made the clarifications to the "Right to Recovery—Third Party Liability" section in Exhibits A through F. The clarifications make clear that the provisions of the section are subject to applicable laws.

14. In Exhibits A through F, in the "General Provisions" section, the Board has added the language "either for Medicare, Medicaid, or" to the second paragraph of the "Termination of the Policy—Renewal" provision in order to make this provision consistent with the Eligibility provisions of the policy forms.

15. Throughout the policy forms, the term "Non-Covered Charge" has been changed to "Non-Covered Expenses" to make the term consistent with other policy form terminology.

16. In Exhibits C, D, and E, in the "Charges Covered With Special Limitations" section, the phrase "psychologist or social worker" have been deleted to make the provision terminology consistent with other plans. This language was changed in the other policy forms at the time of the proposed changes.

17. In Exhibit B, under the definition of "Child," the language "Your step-child" has been deleted as the language is superfluous and has no meaning in the context of the sentence.

18. In Exhibit C, in the "Covered Charges With Special Limitations" section, the word "most" has been deleted in the Therapy Services provision to make the language consistent with the other policy forms.

19. In Exhibit D, in the "Eligibility" section, the Board has added the language "[w]hether or not there is an adult who will be provided coverage" to make the language of this provision consistent with the language of the other policy forms. This omission had not been intentional.

20. In Exhibit F, in the "Definitions" section, in the definition of "Non-Covered Services," the word "expenses" is deleted and the word "Services" is added to provide consistent terminology. In addition, the sentence "Copayments and Coinsurance are also Non-covered Expenses[.]" is deleted because it is superfluous language, and confusing.

21. In Exhibit F, in the "Covered Services and Supplies" section, the Board has added the sentence "Court-ordered Substance Abuse or Mental or Nervous Conditions admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as described below," and the sentence "Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above[.]" is deleted to clarify the treatment of court-ordered admissions for both substance abuse and mental or nervous conditions, and to use consistent language within the provision.

22. In Exhibit F, in the "Covered Services and Supplies" section, a paragraph entitled "Chemical Dependency Admission" has been changed to "Repeat Detoxification Treatment" in order to more accurately reflect the content of the provision.

23. In Exhibit F, in the "Covered Services and Supplies" section, under Alcoholism Benefits, the number "3" has been deleted from the last paragraph to clarify that this is not a standalone provision, rather this preference to Court-ordered admissions extends to all of the provisions within "(e)."

24. In Exhibit F, in the Covered Services And Supplies section, under "Therapy Services," the word "Accidental" was added before "Injury" in order to keep the language consistent within the policy forms.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in cursive brackets with asterisks *{thus}*):

APPENDIX

EXHIBIT A

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for a BASIC health benefits plan.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
BASIC HEALTH BENEFITS PLAN
(New Jersey BASIC Health Benefits Plan)

Policy Term. The Policy takes effect on ***[*_____ *]***, the Policy Effective Date. The term of this Policy starts on your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

. . .

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep

this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this New Jersey BASIC Health Benefits Plan.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page ***[*22*]***.

...

[ALLOWANCE. What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.*{]}*

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and our Allowance under the Policy.***]***

...

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer *{insured}* ***covered by this Policy***. Eligible Medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A Facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

...

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 19;
  (3) unmarried Child from age 19 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supported;
  (2) the Child's condition started before the Child reached this Policy's age limit;
  (3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and
  (4) the Child depends on You for most of the Child's support and maintenance.

  In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

...

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or

(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or

(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   —The American Medical Association Drug Evaluations;
   —The American Hospital Formulary Service Drug Information; or
   —The United States Pharmacopeia Drug Information.
   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

   In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. A place We are required by law to recognize which:

(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

...

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out it**s** a stated purpose under all relevant state and local laws, and it is:

(a) approved for its stated purpose by Medicare**;**

(b) accredited for its stated purpose by the Joint Commission; or

(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out it**s** stated purpose under all relevant state and local laws, and it is:

(a) accredited as a hospital by the Joint Commission*{,}***;**

(b) approved as a Hospital by Medicare**;** or

(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A Facility for the aged or for Substance Abusers is not a Hospital.

A specialty Facility is also not a Hospital.

...

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the secton of this Policy called *{Medical Care}* Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

[*IN-NETWORK PROVIDER.* A Provider which has an agreement with Us to accept Our Allowance plus amounts you are required to pay as payment in full for Covered Charges.]

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such a setting.

...

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. ***Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis*** *{Heart attacks}*, strokes, convulsions, ***serious*** burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness***.*** *{are Medical Emergencies.}* We may, in our Discretion, consider other severe medical conditions requirng immediate attention to be Medical Emergencies.

...

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;

(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;

(c) in accordance with accepted medical standards in the community at the time;

(d) not for Your convenience; and

(e) the most appropriate level of medical care that You need.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental ***or*** *{and}* Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental ***or*** *{and}* Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

*{[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]}*

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments, Coinsurance and Utilization Review Penalties are also Non-covered Expenses.

*{[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]}*

NURSE. A registerd nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

[*OUT-OF-NETWORK PROVIDER.* A Provider which is not an In-Network Provider.]

. . .

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

. . .

POLICY. This agreement, ***[the Policy Schedule,] [Your I.D. card,]*** any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PRACTITIONER. A person [Carrier] is required by law to recognize who:

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and
(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

. . .

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

. . .

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or,
(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; *{or}*
(b) approved for its stated purpose by Medicare*{.}***; or***
(c) licensed, certified, or accredited by the state in which it operates.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

. . .

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission; *{or}*
(b) approved for its stated purpose by Medicare; or

(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified or accredited by the state in which it operates.***

...

SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; *{or}*
(b) approved for its stated purpose by Medicare*{.}***; or**
(c) licensed, certified or accredited by the state in which it operates.*

A Facility is not a Surgical Center if it is part of a Hospital.

...

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Accidental Injury or Illness:

...

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.
(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefits coverage whether or not there is an adult who will be provided coverage.
(d) **HUSBAND AND WIFE *COVERAGE***—coverage under this Policy for You and Your Spouse.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change Your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your ependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED LIFETIME MAXIMUM*, *UNLESS OTHERWISE STATED*.*

FACILITY BENEFIT—30 days Inpatient Hospital care.

FACILITY COINSURANCE—20% up to a maximum of $5000/Covered Person (no benefit after 30 days).

PRACTITIONER'S SERVICES COINSURANCE—50% Inpatient and Outpatient (incl. Surgery, anesthesia, radiology and obstetrics).

NOTE: The Coinsurance Amounts cannot be met with:

- **Non-Covered Expenses**
- **Cash Deductibles**
- **Copayments**

CASH DEDUCTIBLES:

INPATIENT (separate)—$250/day, $1,250/per Period of Confinement/Covered Person; max. of two Inpatient Deductibles/Covered Person.

OTHER COVERED CHARGES—$250/Covered Person, $500/family.

PRIMARY CARE SERVICES—$100/Covered Person, $300/family. Primary Care Services are not subject to Deductibles and Coinsurance.

NOTE: OUR PAYMENTS WILL BE REDUCED FOR NON-COMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are *[*shown in the Policy's Schedule of Premium Rates*]*[:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Husband and Wife ***Coverage*** ..... [$]

We have the right to change any Premium rate set forth *[*above*]* ***[in the Policy's Schedule of Premium Rates]*** at the times

and in the manner established by the provision of this Policy entitled "Premium*{s}* *Rate Changes*."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy]. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described in the *"*General Provisions*"* section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to *{you}* *You* for those *{Charges}* *charges*. For Inpatient Hospital services and supplies and Rehabilitation Center services and supplies not immediately preceded by an Inpatient Hospital *{Stay}* *stay* You must pay one Inpatient Deductible per Period of Confinement before We pay any benefits. For other Covered Charges, each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the *"*Schedule of Benefits*"* section of this Policy. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. However, a Covered Person must satisfy two Inpatient Deductibles per Benefit Period. And all charges must be incurred while You are insured by this Policy. What We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family aggregate deductible cap on care equal to two Deductibles for each Benefit Period. This does not apply to the Inpatient Hospital Deductible. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Facility Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period for the Facility benefit. But We do not provide benefits for more than 30 Inpatient Hospital days per Benefit Period.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy*, **provided that there has been no lapse in coverage between the previous coverage and this Policy***.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

Deductible Carryover: There will be no carryover of Deductibles or Coinsurance into the next Benefit Period. However, a Covered Person will receive credit for any Inpatient Hospital Deductible satisfied during a Period of Confinement immediately preceding or continuing into a new Benefit Period.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans:* When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan which that provides the same or similar coverage. We do this so that no one gets more in benefits than he incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductible, Coinsurance, other limits and exclusions shown in the *"*Schedule of Benefits*"*, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE *"*UTILIZATION REVIEW"* SECTION OF THIS POLICY.**

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Practitioner's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the *"*Schedule of Benefits*"* when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover Inpatient blood transfusions only.

Daily Room and Board Limits*[:
(}*During a Period of Hospital Confinement*{)}*:*

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

*{**Practitioner Charges for Nonsurgical Care and Treatment:** We only cover Practitioner charges for nonsurgical care and treatment of an Illness or Accidental Injury under Primary Care Services. See the "Schedule of Benefits" and "Primary Care Services" sections of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery. But, We do not cover charges for cosmetic Surgery.}*

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan on the basis of two *{Home Health Care}* ***home health care*** days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as:

(a) Skilled Nursing Care furnished by or under the supervision of a registered Nurse;
(b) Therapy Services;
(c) *{Medical}* ***medical*** social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
   1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
   2. The services and supplies must be:
      - ordered by Your Practitioner;
      - included in the home health care plan; and
      - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But, payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility;
(b) the services and supplies must be: (a) ordered by Your Practitioner; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis;
(c) the home health care plan must be set up in writing by Your Practitioner within 14 days after home health care starts;
(d) each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. Additionally, We *{Cover Charges}* ***cover charges*** for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your Practitioner has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy on the basis of two Inpatient Hospice days in exchange for each Inpatient Hospital day relinquished. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
(a) needed for palliative and supportive care;
(b) ordered by Your Practitioner;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:
(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; or
(e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the *"*Schedule of Benefits*"*. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery. However, We do not cover specialist consultations in a Hospital.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic.

We cover emergency room treatment only if such treatment subsequently results in Your admission to a Hospital.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

***Practitioner Charges for Nonsurgical Care and Treatment:* We only cover Practitioner charges for nonsurgical care and treatment of an Illness or Accidental Injury under Primary Care Services. See the "Schedule of Benefits" and "Primary Care Services" sections of this Policy.**

Practitioner Charges for Surgery:* We cover Practitioner charges for surgery. But, we do not cover charges for cosmetic surgery.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Admission Review and Preadmission Testing, Surgery, Chemotherapy, Radiation Therapy and Accidental Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the *"*Utilization Review*"* section of this *{policy}* ***Policy***.

. . .

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second (or third) opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Center: Subject to Our advance written approval, when Skilled Nursing Care can take the place of Inpatient care, We cover such care furnished to You in a Skilled Nursing Center on the basis of two Skilled Nursing Center days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

X-Rays and Laboratory Tests: We cover Inpatient and Outpatient x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no intervening lapse in coverage, You have been treated or diagnosed by a *{physician}* ***Practitioner*** for a condition under that plan or satisfied a 12 month *{preexisting condition}* ***Preexisting Condition*** limitation for a condition covered by that plan.

Primary Care Services: We will cover up to $100 per Covered Person per Benefit Period, up to a maximum of $300 per family per Benefit Period, for routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to Deductibles or Coinsurance.

Therapy Services: We cover Inpatient and Outpatient Chemotherapy and Radiation Therapy. We cover other Therapy Services only on an Inpatient basis. But *{w}**W*e do not cover Dialysis Treatment.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request For Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Hospice Care
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

STEP 2—Notice Requirements

For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase.

For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

[For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 4 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 4 below.

If the second opinion does not confirm the need for the procedure, We may require You to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 4 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, WE WILL NOT PAY FOR THE PROCEDURE NOR ANY ASSOCIATED PROVIDER (INCLUDING FACILITY) CHARGES. IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY ***NECESSARY AND*** APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 4—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what

setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

[IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [Carrier].

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury ***or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home*.**
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"CATASTROPHIC ILLNESS OR INJURY" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - Us
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We *{determines}* ***Determine*** to be Experimental or Investigational.]

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be subject to the terms and conditions of the Policy. [However, the ***requirements of the "*Utilization Review*"*** *{Features}* ***section*** will not apply.]]

IX. [XI] EXCLUSIONS

THE FOLLOWING ARE **NOT** COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not *{medically appropriate}* ***Medically Necessary and Appropriate*.**

Alcoholism.

Ambulance—air, water, ground and rail.

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial *{and surgical}* drugs and ***surgical*** procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization and gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

. . .

Local anesthesia charges billed separately by a Practitioner for surgery he or she performed on an Outpatient basis.

. . .

Routine Foot Care, except when *{determined}* ***Determined*** by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

—eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
—for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
—for which You would not have been charged if You did not have health care coverage;
—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—in an amount greater than a Reasonable and Customary charge;

—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
—provided by or in any locale outside the United States *[, except]* ***other than*** in the case of a *[medical emergency]* ***Medical Emergency, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent***;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
[—provided by a social worker, except as otherwise stated in this Policy;]
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

...

X. [XII.] CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send ***U***[u]*s written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

...

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for recnsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date after We receive Your request for review.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. [XIII.] *COORDINATION OF BENEFITS* *[BENEFITS FROM OTHER PLANS]*

***This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.**

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.*

*[This provision applies to all Covered Charges under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You incur Claims under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount. To the extent You have not paid the full premium amount, We will offset the amount due from any benefit amount payable for Covered Charges.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information

We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.}*

XII. [XIV.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a Third Party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the Third Party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits ***and these amounts were not otherwise deducted from an award, judgement or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97***.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Accidental Injury through:

a. a Third Party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement *{will}* ***shall*** be binding upon the Covered Person whether:

a. the payment received from the Third Party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the Third Party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment *{in whole or in part}* from a Third Party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no-fault tort liability of a Third Party.

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable State or federal law and that other law precludes repayment.

XIII. [XV.] GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or ***that*** of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to *{Coverage}* ***coverage*** under this Policy will reduce Your *{Coverage}* ***coverage***. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility;
(d) You become eligible ***either for Medicare, Medicaid, or*** to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

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OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

. . .

[*{NETWORK}* *IN-NETWORK* AND *{NON-NETWORK}* *OUT-OF-NETWORK* PROVIDER REIMBURSEMENT

Payment amounts, as specified in the *"*Schedule of Benefits*"*, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

{A Network} ***An In-Network*** Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by *{a Non-Network}* ***An Out-of-Network*** Provider may be different than our *{Network}* ***In-Network*** Provider Allowance; also, a *{Non-Network}* ***Out-of-Network*** Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

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PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

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EXHIBIT B

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan B.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN B
(New Jersey Individual Health Benefits Plan B)

Policy Term. The Policy takes effect on *[*_____ *]*, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this New Jersey Individual Health Benefits Plan B.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this Policy. Information about Your benefits begins on page *[*22*]*.

. . .

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer *{insured}* ***covered by this Policy***. Eligible Medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A Facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws; or
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or Your legally adopted child, and Your step-child if the child depends on You for most of the child's support and maintenance*[, Your step-child]*. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or his or her Spouse is not a Child for purposes of eligibility for benefits under this Policy.

. . .

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 19;
  (3) unmarried Child from age 19 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supportive;
  (2) the Child's condition started before the Child reached this Policy's age limit;
  (3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and
  (4) the Child depends on You for most of the Child's support and maintenance.

  In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his ***or her*** support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

. . .

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   —The American Medical Association Drug Evaluations;
   —The American Hospital Formulary Service Drug Information; or
   —The United States Pharmacopeia Drug Information.

   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

   In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. A place We are required by law to recognize which: (a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and (b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

...

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out it**s** stated purpose under all relevant state and local laws, and it is *{either}*:

(a) approved for its stated purpose by Medicare;
(b) accredited for its stated purpose by the Joint Commission; or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out it**s** stated purpose under all relevant state and local laws, and it is:

(a) accredited as a hospital by the Joint Commission,
(b) approved as a Hospital by Medicare; or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A Facility for the aged or for Substance Abusers is not a Hospital.

A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a ***Out-of-Network*** *{[Non-Network]}* Provider due to that Medical Emergency, or Your benefits wil be reduced. See the section of this Policy called "*{Medical Care}* Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

[*IN-NETWORK PROVIDER.* A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognzied health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. ***Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis*** *{Heart attacks}*, strokes, convulsions, ***serious*** burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness**.** *{are Medical Emergencies.}* We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental *{and}* ***or*** Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental *{and}* ***or*** Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

{[NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]}

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments, Coinsurance, and Utilization Review Penalties are also Non-covered Expenses.

{[NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]}

NURSE. A registerd nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

[*OUT-OF-NETWORK PROVIDER.* A Provider which is not an In-Network Provider.]

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, ***[the Policy Schedule,] [Your I.D. card,]*** any riders, amendments or endorsements, and the application signed by You and the premium schedule.

...

PRACTITIONER. A person [Carrier] is required by law to recognize who:

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and
(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

...

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his ***or her*** coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations. See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

. . .

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or

(b) the negotiated fee.

The Board may decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) approved for its stated purpose by Medicare*{.}***; or**

(c) licensed, certified, or accredited by the state in which it operates.*

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare*{.}***; or**

(c) licensed, certified, or accredited by the state in which it operates.*

. . .

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;

(b) approved for its stated purpose by Medicare; or

(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

. . .

SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; *{or}*

(b) approved for its stated purpose by Medicare*{.}***; or**

(c) licensed, certified, or accredited by the state in which it operates.*

A Facility is not a Surgical Center if it is part of a Hospital.

. . .

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Accidental Injury or Illness:

. . .

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit***s*** coverage whether or not there is an adult who will be provided coverage.

(d) **HUSBAND AND WIFE *COVERAGE***—coverage under this Policy for You and Your Spouse.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey and You are not eligible for Medicaid, Medicare or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change *{your}* ***Your*** type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his*{/}* ***or*** her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO PER LIFETIME MAXIMUM OF $1,000,000 *UNLESS OTHERWISE STATED*.

...

COINSURANCE CAP—After $3000/Covered Person, $6,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental *{and}* ***or*** Nervous Conditions and Substance Abuse
- Copayments

...

HOSPICE CARE—Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS—Subject to annual deductible and coinsurance.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

THERAPEUTIC MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Services except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND *"*CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are ***[shown in the Policy's Schedule of Premium Rates]***:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Husband and Wife ***Coverage*** ..... [$]

We have the right to change any Premium rate set forth ***[*above*]* [in the Policy's Schedule of Premium Rates]*** at the times and in the manner established by the provision of this Policy entitled "Premium*{s."]}* ***Rate Changes."]***

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described in the *"*General Provisions*"* section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges ***(subject to the Family Deductible Cap as described below)***. For Inpatient Hospital services and Rehabilitation Center services not immediately preceded by an Inpatient Hospital Stay You must pay an Inpatient Deductible, up to two per Benefit Period, per Period of Confinement before We pay any benefits. For other Covered Charges, each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the *"*Schedule of Benefits*"* section of this Policy. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. This does not apply to the Inpatient Hospital Deductible. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance,

for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Inpatient Hospital Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental *{and}* **or** Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

Deductible Carryover: There will be no carryover of Deductibles or Coinsurance into the next Benefit Period. However, a Covered Person will receive credit for any Inpatient Hospital Deductible satisfied during a Period of Confinement immediately preceding and continuing into a new Benefit Period ***provided that there has been no lapse in coverage between the previous coverage and this Policy***.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than he incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the ***"*Schedule of Benefits*"***, along with other provisions in this Policy.

Covered Charges for services and supplies rendered Inpatient are subject to the Inpatient Hospital Deductible.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Practitioner's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the ***"*Schedule of Benefits*"*** when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the sections of this Policy called "Exclusions."

Daily *{room and board limits}* *Room and Board Limits*

During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered *{dialysis}* ***Dialysis*** Therapy *{Services}* ***services***.

***{Practitioner Charges for Nonsurgical Care and Treatment:** We cover Practitioner charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery. But, We do not cover cosmetic Surgery.]*

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
    1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
    2. The services and supplies must be:
        - ordered by Your Practitioner;
        - included in the home health care plan; and
        - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
(b) The services and supplies must be: (a) ordered by Your Practitioner; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by Your Practitioner within 14 days after home health care starts. And

it must be reviewed by Your Practitioner at least once every 60 days.

(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. Additionally, We *{Cover Charges}* ***cover charges*** for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your Practitioner has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs if You are terminally Ill. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Practitioner;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; or
(e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the *"*Schedule of Benefits*"*. And We cover other Hospital services and supplies provided to You duirng the Inpatient confinement, inclunig Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Reuqirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy Services and Accidental Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the Utilization Review section of this policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

***Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment on an Illness or Accidental Injury. See the "Schedule of Benefits" section of this policy.**

Practitioner Charges for Surgery: We cover Practitioner charges for surgery. But, We do not cover cosmetic surgery.*

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post- admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay Covered Charges incurred for the treatment of Wilm's tumor. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Dental Care and Treatment—We cover:

(a) the diagnosis and treatment of oral tumors and cysts; and
(b) the surgical removal of bony impacted teeth.

We also cover treatment of an Accidental Injury to natural teeth or the jaw, but only if:

(a) the Injury occurs while You are insured under any health benefit plan;
(b) the Injury was not caused, directly or indirectly by biting or chewing; and
(c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Accidental Injury. But in no event do We cover orthodontic treatment.

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or Practitioner.

You must pay Coinsurance of 40% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits that involve monitoring a Covered Person's care when the Covered Person is involved in an ongoing maintenance treatment program for a Mental or Nervous Condition and any associated Prescription Drugs are covered the same as Covered Charges for any other Accidental Injury or Illness. These Covered

Charges are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no intervening lapse in coverage, You have been treated or diagnosed by a *{physician}* ***Practitioner*** for a condition under that plan or satisfied a 12 month *{pre-existing condition}* ***Pre-existing Condition*** limitation for a condition covered by that plan.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Private Duty Nursing Care: We only cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are *{a}* Non-Covered *{Charge}* ***Expenses***.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, unless they are Medically Necessary and Appropriate*{,}***.*** We do not pay for repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for Therapy Services other than Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ)*:*

We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogeneic Bone Marrow
(j) Autologous Bone Marrow and Associated High Dose Chemotherapy only for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- *{Aplastic Anemia
- Genetic Disorders
  - SCID
  - WISCOT Alldrich}*
- Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered *{Charges}* ***Expenses***.

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

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request For Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT Scan
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Ambulance for Non-Medical Emergency
Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

STEP 2—Notice Requirements

For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase.

For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

[For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact Us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 4 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 4 below.

If the second opinion does not confirm the need for the procedure, We may require You to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 4 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, WE WILL NOT PAY FOR THE PROCEDURE NOR ANY ASSOCIATED PROVIDER (INCLUDING FACILITY) CHARGES. IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY *NECESSARY AND* APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 4—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES **WILL BE REDUCED BY 50%.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

[IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury ***or in completing a course of care outside of the acute hospital setting, for example completing a course of IV antibiotics at home*.**
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"CATASTROPHIC ILLNESS OR INJURY" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - Us
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We determine*{s}* to be Experimental or Investigational.]

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the ***requirements of the "*Utilization Review*" section*** *{Features}* will not apply.]]

IX. [XI.] EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not *{m}***M***edically ***Necessary and*** *{a}***A***ppropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Any change to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial *{and surgical}* drugs and ***surgical*** procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

. . .

Dental care or treatment (including appliances) except as otherwise specifically Covered.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or training while You are confined in an institution that is primarily an institution for learning or training.

Extraction of teeth*{, including bony impacted teeth}* ***except as otherwise specifically covered****.

. . .

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

. . .

Local anesthesia charges billed separately by a Practitioner for surgery he or sheperformed on an Outpatient basis.

. . .

Private-Duty Nursing, unless you have followed the section of this Policy called "Request For Care Preapproval."

. . .

Routine Foot Care, except when determined by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
- —for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
- —provided by or in any locale outside the United States *{, except}* ***other than*** in the case of a Medical Emergency***, unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent****;
- —provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
- *{—provided by a social worker, except as otherwise stated in this Policy;}*
- —received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- —rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
- —which are specifically limited or excluded elsewhere in this Policy;
- —which are not Medically Necessary and Appropriate; or
- —which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation.)

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. [XII.] CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send *{us}* ***Us*** written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

. . .

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We

reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date after We receive Your request for review.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. [XIII.] *COORDINATION OF BENEFITS* *{BENEFITS FROM OTHER PLANS}*

***This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.**

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.*

*{This provision applies to all Covered Charges under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You incur Claims under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount. To the extent You have not paid the full premium amount, We will offset the amount due from any benefit amount payable for Covered Charges.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.}*

[XII. [XIV.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a Third Party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a Third Party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the Third Party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits ***and these amounts were not otherwise deducted from an award, judgement or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97***.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the Third Party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Accidental Injury through:

a. a Third Party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement *{will}* ***shall*** be binding upon the Covered Person whether:

a. the payment received from the Third Party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the Third Party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment *{in whole or in part}* from a Third Party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no-fault tort liability of a Third Party.*{]}*

***This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some**

other applicable state or federal law and that other law preclude such repayment.]*

XII. [XIV.] [XV.] GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

...

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to *{C}* ***c***overage under this Policy will reduce Your *{C}***c***overage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;
(d) You become eligible ***either for Medicare, Medicaid, or*** to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

...

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

...

[*{NETWORK}* *IN-NETWORK* AND *{NON-NETWORK}* *OUT-OF-NETWORK* PROVIDER REIMBURSEMENT

Payment amounts, as specified in the *"*Schedule of Benefits*"*, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

{A Network} ***An In-Network*** Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by *{a Non-Network}* ***an Out-of-Network*** Provider may be different than our *{Network}* ***In-Network*** Provider Allowance; also, *{a Non-Network}* ***an Out-of-Network*** Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

...

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

...

EXHIBIT C

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan C.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
BASIC HEALTH BENEFITS PLAN C
(New Jersey Individual Health Benefits Plan C)

Policy Term. The Policy takes effect on *[*_____ *]*, the Policy Effective Date. The term of this Policy starts on your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this New Jersey Individual Health Benefits Plan C.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page *[*22*]*.

...

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer *{insured}* ***covered by this Policy***. *{Eligible medical expenses must be incurred during this period in order to be Covered Charges.}*

BIRTHING CENTER. A Facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

...

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

...

DEPENDENT.

(a) Your:
(1) Spouse;
(2) unmarried Child who is under age 19;
(3) unmarried Child from age 19 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to be self-supportive;
(2) the Child's condition started before the Child reached this Policy's age limit;
(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and
(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his ***or her*** support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

...

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalization in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective

and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   - —The American Medical Association Drug Evaluations;
   - —The American Hospital Formulary Service Drug Information; or
   - —The United States Pharmacopeia Drug Information.

   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

   In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. A place We are required by law to recognize which:
- (a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
- (b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

...

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out it**s** stated purpose under all relevant state and local laws, and it is:
- (a) approved for its stated purpose by Medicare;
- (b) accredited for its stated purpose by the Joint Commission; or
- (c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out it**s** stated purpose under all relevant state and local laws, and it is:
- (a) accredited as a hospital by the Joint Commission*{, or}**;*
- (b) approved as a Hospital by Medicare*; or*
- (c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A Facility for the aged or for Substance Abusers is not a Hospital. A specialty Facility is also not a Hospital.

...

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provide due to that Medical Emergency or Your benefits will be reduced. See the section of this Policy called "*{Medical Care}* Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

[IN-NETWORK PROVIDER. A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. ***Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis*** *{Heart attacks}*, strokes, convulsions, ***serious*** burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness**.** *{are Medical Emergencies.}* We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:
- (a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
- (b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
- (c) in accordance with accepted medical standards in the community at the time;
- (d) not for Your convenience; and
- (e) the most appropriate level of medical care that You need.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:
- (a) accredited for its stated purpose by the Joint Commission;
- (b) approved for its stated purpose by Medicare; or
- (c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental *{and}* ***or*** Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental *{and}* ***or*** Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

{[NETWORK PROVIDER. A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]}

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments, Coinsurance, and Utilization Review Penalties are also Non-covered Expenses.

{[NON-NETWORK PROVIDER. A Provider which is not a Network Provider.]}

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and

(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

[OUT-OF-NETWORK PROVIDER. A Provider which is not an In-Network Provider.]

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and

(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, ***[The Policy Schedule,] [Your I.D. card,]*** any riders, amendments or endorsements, and the application signed by You and the premium schedule.

...

PRACTITIONER. A person [Carrier] is required by law to recognize who:

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and

(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

...

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before *{his/her}* ***his or her*** coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

...

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [*{less}* ***lesser*** of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or

(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; *{or}*

(b) approved for its stated purpose by Medicare*{.}***; or**

(c) licensed, certified, or accredited by the state in which it operates.*

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by the Joint Commission; *{or}*

(b) approved for its stated purpose by Medicare*{.}***; or**

(c) licensed, certified, or accredited by the state in which it operates.*

...

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;

(b) approved for its stated purpose by Medicare; or

(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

...

SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; *{or}*

(b) approved for its stated purpose by Medicare*{.}***; or**

(c) licensed, certified, or accredited by the state in which it operates.*

A Facility is not a Surgical Center if it is part of a Hospital.

...

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Accidental Injury or Illness:

...

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.

(d) **HUSBAND AND WIFE *COVERAGE***—coverage under this Policy for You and Your Spouse.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, or who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change *{your}* ***Your*** type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of *{his/her}* ***his or her*** eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM *UNLESS OTHERWISE STATED*.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—30%

OTHER COVERED CHARGES—30% up to $2,500/Covered Person, $5,000/family.

COINSURANCE CAP—After $2,500/Covered Person, $5,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental *{and}* ***or*** Nervous Conditions and Substance Abuse
- Copayments

CASH DEDUCTIBLE—[$250] [$500] [$1,000]/Covered Person, [$500] [$1,000] [$2,000]/family

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS—Subject to annual deductible and coinsurance.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

THERAPEUTIC MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Services except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND *""CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The *[*monthly*]* premium rates, in U.S. dollars, for the insurance provided under this Policy are ***[shown in the Policy's Schedule of Premium Rates]***:

For Single Coverage ..... [$]

For Parent and Child(ren) Coverage ..... [$]

For Family Coverage ..... [$]

For Husband and Wife ***Coverage*** ..... [$]

We have the right to change any Premium rate set forth *[*above*] **[in the Policy's Schedule of Premium Rates]*** at the times and in the manner established by the provision of this Policy entitled "Premium*{s."]}* ***Rate Changes."]***

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date *[*stated *{[}*on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's [Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described in the General Provisions section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits ***to you for those charges*** (subject to the Family Deductible Cap as described below) *{to You for those charges}*. The Deductibles are shown in the *"*Schedule of Benefits*"* section of this Policy. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by *{the}* You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental *{and}* ***or*** Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his or her own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy*, **provided that there has been no lapse in coverage between the previous coverage and this policy***.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: **When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than he incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.***

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the *"*Schedule of Benefits*"*, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Practitioner's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the *"*Schedule of Benefits*"* when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the *{child}* ***Child*** is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the section of the Policy called "Exclusions."

Daily *{room and board limits}* *Room and Board Limits* During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered *{dialysis}* ***Dialysis*** Therapy *{Services}* ***services***.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services***;***
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
    1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
    2. The services and supplies must be:
        - ordered by Your Practitioner;
        - included in the home health care plan; and
        - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
(b) The services and supplies must be: (a) ordered by Your Practitioner; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by Your Practitioner within 14 days after home health care starts. And it must be reviewed by Your Practitioner at least once every 60 days.
(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. Additionally, We *{Cover Charges}* ***cover charges*** for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your Practitioner has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs *{If Your}* ***if You*** are terminally Ill. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Practitioner;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; or
(e) services supplied to family members who are not Covered Persons.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the ***"*Schedule of Benefits***"***. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If your incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy and Accidental Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the ***"*Utilization Review***"*** section of this policy.

. . .

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when *{we}* ***We*** require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay Covered Charges incurred for the treatment of Wilm's tumor. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Dental Care and Treatment

We cover:

(a) the diagnosis and treatment of oral tumors and cysts; and

(b) the surgical removal of bony impacted teeth.

We also cover treatment of an Accidental Injury to natural teeth or the jaw, but only if:

(a) the Injury occurs while You are insured under any health benefit plan;

(b) the Injury was not caused, directly or indirectly by biting or chewing; and

(c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Accidental Injury. But in no event do We cover orthodontic treatment.

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental *{and}* ***or*** nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any Practitioner*{, psychologist or social worker}*.

You must pay Coinsurance of 30% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits that involve monitoring a Covered Person's care when the Covered Person is involved in an ongoing maintenance treatment program for a Mental or Nervous Condition and any associated Prescription Drugs are covered the same as Covered Charges for any other Accidental Injury or Illness. These Covered Charges are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no intervening lapse in coverage, You have been treated or diagnosed by a *{physician}* ***Practitioner*** for a condition under that plan or satisfied a 12 month *{Pre-existing}* ***Pre-Existing*** Condition limitation for a condition covered by that plan.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Private Duty Nursing Care: [Carrier] ***We*** **only** cover*{s}* charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part f a home health care plan, coordinated by a Home Health Agency, and covered under the ***"*Home Health Care Charges***** section. Any other charges for private duty nursing care are *{a}* Non-Covered *{Charge}* ***Expense***.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, unless they are Medically Necessary and Appropriate. We do not pay for repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for *{most}* Therapy Services other than Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ)

We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogeneic Bone Marrow
(j) Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- *{Aplastic Anemia
- Genetic Disorders
  - SCID
  - WISCOT Alldrich}*
- Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered *{Charges}* *Expenses***.

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

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request For Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk

Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT Scan
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Ambulance for Non-Medical Emergency
Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

STEP 2—Notice Requirements

For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase.

For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

[For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL **REDUCE ANY PAYMENT BY 50%.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 4 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 4 below.

If the second opinion does not confirm the need for the procedure, We may require You to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 4 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, WE WILL NOT PAY FOR THE PROCEDURE NOR ANY ASSOCIATED PROVIDER (INCLUDING FACILITY) CHARGES. IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY *NECESSARY AND* APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 4—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, **ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

[IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury ***or in completing a course of care outside of the acute hospital setting, for example, completing a course of IV antibiotics at home*.**
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"CATASTROPHIC ILLNESS OR INJURY" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by We through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - Us
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We determine*{s}* to be Experimental or Investigational.]

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the ***requirements of the "*Utilization Review*" section*** *{Features}* will not apply.]]

IX. [XI.] EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not *{medically appropriate}* ***Medically Necessary and Appropriate***.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Artificial *{and surgical}* drugs and ***surgical*** procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian transfer (GIFT), and surrogate motherhood.

...

Dental care or treatment (including appliances) except as otherwise specifically Covered.

...

Extraction of teeth*{, including bony impacted teeth}* ***except as otherwise specifically covered***.

...

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

...

Local anesthesia charges billed separately by a Practitioner for surgery he or she performed on an Outpatient basis.

...

Private-Duty Nursing, unless You have followed the section of this Policy called "Request For Care Preapproval."

...

Routine Foot Care, except when *{determined}* ***Determined*** by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

—eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
—for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
—for which You would not have been charged if You did not have health care coverage;
—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—in an amount greater than a Reasonable and Customary charge;
—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
—provided by or in any locale outside the United States*{, except}* ***other than*** in the case of a Medical Emergency***, unless received by a Dependent who is attending an accredited school in a foreign country under the terms stated in the definition of Dependent***;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—*{provided by a social worker, except as otherwise stated in this Policy;}*
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

...

Telephone consultations, except as We may request.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

. . .

X. [XII.] CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send *{us}* *Us* written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

. . .

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date after We receive Your request for review.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. [XIII.] *COORDINATION OF BENEFITS* *{BENEFITS FROM OTHER PLANS}*

***This provision applies to all Covered Charges under this Policy. [It does not apply to death, dismemberment, or loss of income benefits.]**

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.*

*{This provision applies to all Covered Charges under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You incur Claims under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount. To the extent You have not paid the full premium amount, We will offset the amount due from any benefit amount payable for Covered Charges.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.}*

[XII. [XIV.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as

amounts paid for health benefits for which We paid benefits ***and those amounts were not otherwise deducted from an award, judgement or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97***.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Accidental Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement *{will}* ***shall*** be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment *{in whole or in part}* from a third party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.*{]}* ***This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable state or federal law and that other law precludes such repayment.]***

XII. [XIV.] [XV.] GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

. . .

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;
(d) You become eligible ***either for Medicare, Medicaid, or*** to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

. . .

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

. . .

[*{NETWORK}* *IN-NETWORK* AND *{NON-NETWORK}* *OUT-OF-NETWORK* PROVIDER REIMBURSEMENT

Payment amounts, as specified in the *"*Schedule of Benefits*"*, apply to Covered Charges incurred for services rendered or supplies provied by an eligible Provider.

{A Network} ***An In-Network*** Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by *{a Non-Network}* ***an Out-of-Network*** Provider may be different than our *{Network}* ***In-Network*** Provide Allowance; also, *{a Non-Network}* ***an Out-of-Network*** Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

. . .

EXHIBIT D

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan D.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN D
(New Jersey Individual Health Benefits Plan D)

Policy Term. The Policy takes effect on *[*_____ *]*, the Policy Effective Date. The term of this Policy starts on your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision: Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan D.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page *[*23*]*.

...

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer *{insured}* ***covered by this Policy***. Eligible medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A Facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or Your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or his or her Spouse is not a Child for purposes of eligibility for benefits under this Policy.

...

DEPENDENT.
(a) Your:
(1) Spouse;
(2) unmarried Child who is under age 19;
(3) unmarried Child from age 19 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to be self-supportive;
(2) the Child's condition started before the Child reached this Policy's age limit;
(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and
(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his ***or her*** support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

...

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalization in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:
1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
—The American Medical Association Drug Evaluations;
—The American Hospital Formulary Service Drug Information; or
—The United States Pharmacopeia Drug Information.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. A place We are required by law to recognize which:
(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

...

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out it***s*** stated purpose under all relevant state and local laws, and it is *{either}*:
(a) approved for its stated purpose by Medicare;
(b) accredited for its stated purpose by the Joint Commission; or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out it***s*** stated purpose under all relevant state and local laws, and it is *{either}*:
(a) accredited as a hospital by the Joint Commission*{, or}***;***
(b) approved as a Hospital by Medicare***;*** or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A Facility for the aged or for Substance Abusers is not a Hospital.

A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "*{Medical Care}* Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

[IN-NETWORK PROVIDER. A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. ***Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis*** *{Heart attacks}*, strokes, convulsions, ***serious*** burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness***.*** *{are Medical Emergencies.}* We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental * {and}* ***or*** Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

*{[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]}*

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments, Coinsurance, and Utilization Review Penalties are also Non-covered Expenses.

*{[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]}*

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

[OUT-OF-NETWORK PROVIDER. A Provider which is not an In-Network Provider.]

OUTPATIENT PROVIDER. You, if You are not an Inpatient; or services and supplies provided in such a setting.

. . .

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, ***[the Policy Schedule,] [Your I.D. card,]*** any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

. . .

PRACTITIONER. A person [Carrier] is required by law to recognize who:

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and
(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

. . .

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

. . .

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or
(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; *{or}*
(b) approved for its stated purpose by Medicare*{.}***; or**
(c) **licensed, certified, or accredited by the state in which it operates.***

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed

Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by the Joint Commission; *{or}*

(b) approved for its stated purpose by Medicare*{.}**; **or**

(c) licensed, certified, or accredited by the state in which it operates.*

...

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:

(a) accredited for its stated purpose by the Joint Commission;

(b) approved for its stated purpose by Medicare*;* or

(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

...

SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; *{or}*

(b) approved for its stated purpose by Medicare*{.}**; **or**

(c) licensed, certified, or accredited by the state in which it operates.*

A Facility is not a Surgical Center if it is part of a Hospital.

...

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Accidental Injury or Illness:

...

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health*s* benefit coverage ***whether or not there is an adult who will be provided coverage***.

(d) **HUSBAND AND WIFE *COVERAGE***—coverage under this Policy for You and Your Spouse.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, or who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his or her eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM *UNLESS OTHERWISE STATED*.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—25%.

OTHER COVERED CHARGES—20% up to $2,000/Covered Person, $4,000/family.

COINSURANCE CAP—After $2,000/Covered Person, $4,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental *{and}* ***or*** Nervous Conditions and Substance Abuse
- Copayments

CASH DEDUCTIBLE—[$250] [$500] [$1,000]/Covered Person, [$500] [$1,000] [$2,000]/family.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS—Subject to annual deductible and coinsurance.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

THERAPEUTIC MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Services except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS AREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The *[*monthly*]* premium rates, in U.S. dollars, for the insurance provided under this Policy are ***[shown in the Policy's Schedule of Premium Rates]***:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Husband and Wife ***Coverage*** ..... [$]

We have the right to change any Premium rate set forth *[*above*] **[in the Policy's Schedule of Premium Rates]*** at the times and in the manner established by the provision of this Policy entitled "Premium*{s."]}* ***Rate Changes."]***

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date *[*stated *{[}*on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the *{[}*Premium Due Date. Those days are known as the grace period. You are liable to pay *[*Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy*[*'s *{[}*Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described in the *"*General Provisions*"* section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges (subject to the Family Deductible Cap as described below). The Deductibles are shown in the *"*Schedule of Benefits*"* section of this Policy. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by *{the}* You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet *{his/her}* ***his or her*** own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy***, provided that there has been no lapse in coverage between the previous coverage and this Policy***.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than he incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the *"*Schedule of Benefits*"*, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the *{child}* ***Child*** is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the *{child}* ***Child*** is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Practitioner's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the ***"*Schedule of Benefits*"** when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions except as limited in the section of this Policy called "Exclusions."

Daily *{room and board limits}* *Room and Board Limits*

During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered *{dialysis}* ***Dialysis*** Therapy *{Services}* ***services***.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
   1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
   2. The services and supplies must be:
      - ordered by Your Practitioner;
      - included in the home health care plan; and
      - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
(b) The services and supplies must be: (a) ordered by Your Practitioner; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part- time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by Your Practitioner within 14 days after home health care starts. And it must be reviewed by Your Practitioner at least once every 60 days.
(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. Additionally, We Cover Charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your Practitioner has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Practitioner;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; or
(e) services supplied to family members who are not Covered Persons.

...

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the ***"*Schedule of Benefits*"***. And We cover other Hospital services

and supplies provided to You during the Inpatient confinement, including surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy Services and Accidental Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the *"*Utilization Review*"* section of this *{policy}* ***Policy***.

. . .

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If You fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay covered charges incurred for the treatment of Wilm's tumor. We treat such charges the same way We treat covered charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Dental Care and Treatment

We cover:

(a) the diagnosis and treatment of oral tumors and cysts; and
(b) the surgical removal of bony impacted teeth.

We also cover treatment of an Accidental Injury to natural teeth or the jaw, but only if:

(a) the Injury occurs while You are insured under any health benefit plan;
(b) the Injury was not caused, directly or indirectly by biting or chewing; and
(c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Accidental Injury. But in no event do We cover orthodontic treatment.

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or *{any}* properly licensed or certified Practitioner*{, psychologist or social worker}*.

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits that involve monitoring a Covered Person's care when the Covered Person is involved in an ongoing maintenance treatment program for a Mental or Nervous Condition and any associated Prescription Drugs are covered the same as Covered Charges for any other Accidental Injury or Illness. These Covered Charges are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no intervening lapse in coverage, You have been treated or diagnosed by a *{physician}* ***Practitioner*** for a condition under that plan or satisfied a 12 month *{preexisting condition}* ***Pre-Existing Condition*** limitation for a condition covered by that plan.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Private Duty Nursing Care: We **only** cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the ***"*Home Health Care Charges*"*** section. Any other charges for private duty nursing care are *{a}* Non-Covered *{Charge}* ***Expenses***.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, unless they are Medically Necessary and Appropriate, We do not pay for repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for Therapy Services other than Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy.

We cover Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ)

We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogeneic Bone Marrow

(j) Autologous Bone Marrow and Associated High Dose Chemotherapy only for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- *{• Aplastic Anemia
- Genetic Disorders
  - SCID
  - WISCOT Alldrich}*
- Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered *{Charges}* *Expenses*.**

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

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request For Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT Scan
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Ambulance for Non-Medical Emergency
Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

STEP 2—Notice Requirements

For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase.

For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

[**For Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL REDUCE ANY PAYMENT BY 50%.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 4 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 4 below.

If the second opinion does not confirm the need for the procedure, We may require You to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 4 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, WE WILL NOT PAY FOR THE PROCEDURE NOR ANY ASSOCIATED PROVIDER (INCLUDING FACILITY) CHARGES. IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY *NECESSARY AND* APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 4—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. IF WE DO **NOT** AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES **WILL BE REDUCED BY 50%**.

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

[IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury ***or in completing a course of care outside of the acute hospital setting, for example, completing a course of IV antibiotics at home***.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"CATASTROPHIC ILLNESS OR INJURY" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - Us
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We *{determines}* ***Determine*** to be Experimental or Investigational.]

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the ***requirements of the "*Utilization Review*" section*** *{Features}* will not apply.]]

IX. [XI.] EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not *{medically appropriate}* ***Medically Necessary and Appropriate***.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial *{and surgical}* drugs and ***surgical*** procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

. . .

Dental care or treatment (including appliances) except as otherwise specifically *{covered}* ***Covered***.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth*{, including bony impacted teeth}* ***except as otherwise specifically covered***.

. . .

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

. . .

Local anesthesia charges billed separately by a Practitioner for surgery he or she performed on an Outpatient basis.

. . .

Private-Duty Nursing, unless You have followed the section of this Policy called "Request For Care Preapproval."

. . .

Routine Foot Care, except when *{determined}* ***Determined*** by Us to be Medically Necessary and Appropriate due to an Accidental Injury

or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

—eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;

—for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

—for which You would not have been charged if You did not have health care coverage;

—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;

—for which the Provider has not received a certificate of need or such other approvals as are required by law;

—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;

—in an amount greater than a Reasonable and Customary charge;

—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;

—provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.

—provided by or in any locale outside the United States*{, except}* ***other than*** in the case of a Medical Emergency*, **unless received by a Dependent who is attending an accredited school in a foreign country under the terms stated in the definition of a Dependent***;

—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;

—*{provided by a social worker, except as otherwise stated in this Policy;}*

—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;

—rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;

—which are specifically limited or excluded elsewhere in this Policy;

—which are not Medically Necessary and Appropriate; or

—which You are not legally obligated to pay.

...

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

...

X. [XII.] CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send *{us}* ***Us*** written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

...

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;

(b) Policyholder's [identification] number;

(c) date of service;

(d) claim number;

(e) Provider's name; and

(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date after We receive Your request for review.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. [XIII.] *COORDINATION OF BENEFITS* *{BENEFITS FROM OTHER PLANS}*

***This provision applies to all Covered Charges under this Policy. [It does not apply to death, dismemberment, or loss of income benefits.]**

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action.

When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.*

*{This provision applies to all Covered Charges under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges

first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You incur Claims under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount. To the extent You have not paid the full premium amount, We will offset the amount due from any benefit amount payable for Covered Charges.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.}*

[XII. [XIV.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits ***and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court in this State, pursuant to N.J.S.A. 2A:15-97****.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement *{will}* ***shall*** be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment *{in whole or in part}* from a third party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no-fault tort liability of a Third Party.*{]}*

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable state or federal law and that other law precludes such repayment.]

XII. [XIV.] [XV.] GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

...

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to *{Coverage}* ***coverage*** under this Policy will reduce Your *{Coverage}* ***coverage***. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;
(d) You become eligible ***either for Medicare, Medicaid or**** to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

...

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

. . .

[*{NETWORK}* *IN-NETWORK* AND *{NON-NETWORK}* *OUT-OF-NETWORK* PROVIDER REIMBURSEMENT

Payment amounts, as specified in the *"*Schedule of Benefits*"*, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

{A Network} ***An In-Network*** Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by *{a Non-Network}* ***an Out-of-Network*** Provider may be different than our *{Network}* ***In-Network*** Provider Allowance; also, *{a Non-Network}* ***an Out-of-Network*** Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

. . .

EXHIBIT E

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan E.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN E
(New Jersey Individual Health Benefits Plan E)

Policy Term. The Policy takes effect on *[*_____ *]*, the Policy Effective Date. The term of this Policy starts on your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms anbd provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We over under this New Jersey Individual Health Benefits Plan E.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page *{23}* ***[20]***.

. . .

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your

Effective Date. Your last Benefit Period ends when You are no longer *{insured}* ***covered by this Policy***. Eligible medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A Facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or Your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or his or her Spouse is not a Child for purposes of eligibility for benefits under this Policy.

...

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 19;
  (3) unmarried Child from age 19 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supportive;
  (2) the Child's condition started before the Child reached this Policy's age limit;
  (3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until reaching such limit; and
  (4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his ***or her*** support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

...

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   —The American Medical Association Drug Evaluations;
   —The American Hospital Formulary Service Drug Information; or
   —The United States Pharmacopeia Drug Information.
   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.
   In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. A place We are required by law to recognize which:
(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

...

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out it**s** stated purpose under all relevant state and local laws, and it is *{either}*:
(a) approved for its stated purpose by Medicare,
(b) accredited for its stated purpose by the Joint Commission, or
(c) *{accredited or licensed by the State of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out it**s** stated purpose under all relevant state and local laws, and it is:
(a) accredited as a hospital by the Joint Commission,
(b) approved as a Hospital by Medicare, or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A Facility for the aged or for Substance Abusers is not a Hospital.

A specialty Facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "*{Medical Care}* Utilization Review**" for details.

[IN-NETWORK PROVIDER. A Provider which has an agreement with Us to accept our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nevour Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. ***Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis*** *{Heart attacks}*, strokes, convulsions, ***serious*** burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness**.** *{are Medical Emergencies.}* We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:
(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:
(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transent or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

*{[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]}*

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments, Coinsurance, and Utilization Review Penalties are also Non-covered Expenses.

*{[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]}*

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

...

[OUT-OF-NETWORK PROVIDER. A Provider which is not an In-Network Provider.]

...

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, ***[the Policy Schedule,] [Your I.D. card,]*** any riders, amendments or endorsements, and the application signed by You and the premium schedule.

...

PRACTITIONER. A person [Carrier] is required by law to recognize who:
(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and
(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, X-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his **or her** coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

...

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the [lesser of:
(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or
(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:
(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities,
(b) approved for its stated purpose by Medicare, or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:
(a) accredited for its stated purpose by the Joint Commission; *{or}*
(b) approved for its stated purpose by Medicare*{.}***; or**
(c) licensed, certified, or accredited by the state in which it operates.*

...

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is:
(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

...

SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:
(a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is *{either}*:
(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care,
(b) approved for its stated purpose by Medicare or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

A Facility is not a Surgical Center if it is part of a Hospital.

...

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat or promote recovery from an Accidental Injury or Illness:

...

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:
(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.
(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.
(d) **HUSBAND AND WIFE *COVERAGE***—coverage under this Policy for You and Your Spouse.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if Your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, or who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change *{your}* ***Your*** type of coverage. If *{your}* ***Your*** application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his or her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the

Child's becoming a Dependent, the Child will be covered from the date of his ***or her*** eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—25%.

OTHER COVERED CHARGES—10% up to $1,500/Covered Person, $3,000/family.

COINSURANCE CAP—After $1,500/Covered Person, $3,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental *{and}* ***or*** Nervous Conditions and Substance Abuse
- Copayments

CASH DEDUCTIBLE—[$150] [$500] [$1,000]/Covered Person, [$300] [$1,000] [$2,000]/family.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS—Subject to annual deductible and coinsurance.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

THERAPEUTIC MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Services except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The *[*monthly*]* premium rates, in U.S. dollars, for the insurance provided under this Policy are ***[shown in the Policy's Schedule of Premium Rates]***:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Husband and Wife ***Coverage*** ..... [$]

We have the right to change any Premium rate set forth ***[*above*] [in the Policy's Schedule of Premium Rates]*** at the times and in the manner established by the provision of this Policy entitled "Premium*{s."]}* ***Rate Changes."]***

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately after the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy[. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law].

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's [Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described in the *"*General Provisions*"* section of this Policy.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges ***(subject to the Family Deductible Cap as described below)***. The Deductibles are shown in the Schedule of Benefits section of this Policy. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by *{the}* You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based

on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses and Coinsurance for the treatment of Mental *{and}* ***or*** Nervous Conditions and Substance Abuse.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his*{/her}* ***or her*** own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Deductible Credit: For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy***, provided that there has been no lapse in coverage between the previous coverage and this Policy****.

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than he incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.*

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the *"* Schedule of Benefits*"*, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE *"*UTILIZATION REVIEW" SECTION OF THIS POLICY.**

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Practitioner. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible Facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Practitioner other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the *{child}* ***Child*** is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Practitioner's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the *"*Schedule of Benefits*"* when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the *{child}* ***Child*** is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the section of this Policy called "Exclusions."

Daily *{room and board limits}* ***Room and Board Limits**

During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered *{dialysis}* ***Dialysis*** Therapy *{Services}* ***services****.

Practitioner Charges for Nonsurgical Care and Treatment: We cover Practitioner charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

Practitioner Charges for Surgery: We cover Practitioner charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
   1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
   2. The services and supplies must be:
      —ordered by Your Practitioner;
      —included in the home health care plan; and
      —furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
(b) The services and supplies must be: (a) ordered by Your Practitioner; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by Your Practitioner within 14 days after home health care starts. And it must be reviewed by Your Practitioner at least once every 60 days.

(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. Additionally, We *{Cover Charges}* ***cover charges*** for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your Practitioner has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Practitioner;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; or
(e) services supplied to family members who are not Covered Persons.

...

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the *"*Schedule of Benefits*"*. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with covered Admission Review and Preadmission Testing, Surgery, Therapy and Accidental Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the *"*Utilization Review*"* section of this *{policy}* ***Policy***.

...

Second Opinion Charges: We cover Practitioner charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If *{you}* ***You*** fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care Facility, provided such service is administered in a Skilled Nursing Center.

Treatment of Wilm's Tumor: We pay Covered Charges incurred for the treatment of Wilm's tumor. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Dental Care and Treatment—We cover:

(a) the diagnosis and treatment of oral tumors and cysts; and
(b) the surgical removal of bony impacted teeth.

We also cover treatment of an Accidental Injury to natural teeth or the jaw, but only if:

(a) the Injury occurs while You are insured under any health benefit plan;
(b) the Injury was not caused, directly or indirectly by biting or chewing; and
(c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Accidental Injury. But in no event do We cover orthodontic treatment.

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental *{and}* ***or*** nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or *{[any]* properly licensed or certified Practitioner*{, psychologist or social worker]}*.

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits that involve monitoring a Covered Person's care when the Covered Person is involved in an ongoing maintenance treatment program for a Mental or Nervous Condition and any associated Prescription Drugs are covered the same as Covered Charges for any other Accidental Injury or Illness. These Covered Charges are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child or complications of pregnancy as defined in N.J.A.C. 11:1-4.3. We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan delivered or issued for delivery in the United States, with no intervening lapse in coverage, You have been treated or diagnosed by a *{physician}* ***Practitioner*** for a condition under that plan or satisfied a 12 month *{preexisting condition}* ***Pre-Existing Condition*** limitation for a condition covered by that plan.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Private Duty Nursing Care: We **only** cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such

care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the ***"*Home Health Care Charges**** section. Any other charges for private duty nursing care are *{a}* Non-Covered *{Charge}* ***Expense***.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, unless they are Medically Necessary and Appropriate, We do not pay for repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for Therapy Services other than Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy.

We cover Radiation Therapy, Chemotherapy Chelation, Dialysis and Respiration Therapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ): We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

Transplants: We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogeneic Bone Marrow
(j) Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:
- Leukemia
- Lymphoma
- Neuroblastoma
- *{Aplastic Anemia
- Genetic Disorders
  - SCID
  - WISCOT Alldrich}*
- Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered *{Charges}* ***Expenses***.

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

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request For Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
Tympanotomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT Scan
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Ambulance for Non-Medical Emergency
Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

STEP 2—Notice Requirements

For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase.

For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

[For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL **REDUCE ANY PAYMENT BY 50%.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 3—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 4 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 4 below.

If the second opinion does not confirm the need for the procedure, We may require You to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 4 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, WE WILL NOT PAY FOR THE PROCEDURE NOR ANY ASSOCIATED PROVIDER (INCLUDING FACILITY) CHARGES. IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, OUR PAYMENT FOR THE PROCEDURE WILL BE REDUCED BY 20% PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY ***NECESSARY AND*** APPROPRIATE, WE WILL NOT MAKE ANY PAYMENT.

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 4—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, ANY PAYMENT FOR FACILITY CHARGES **WILL BE REDUCED BY 50%.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

[IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

"ALTERNATE TREATMENT" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury ***or in completing a course of care outside of the acute hospital setting, for example, completing a course of IV antibiotics at home***.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"CATASTROPHIC ILLNESS OR INJURY" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by We through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - Us
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We *{determines}* ***Determines*** to be Experimental or Investigational.]

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the ***requirements of the "*Utilization Review*" section*** *{Features}* will not apply.]]

IX. [XI.] EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not *{medically appropriate}* ***Medically Necessary and Appropriate***.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request For Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial *{and surgical}* drugs and ***surgical*** procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment (including appliances) except as otherwise specifically *{Covered}* ***covered***.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth*{, including bony impacted teeth}* ***except as otherwise specifically covered***.

Eye examinations to *{determine}* ***Determine*** the need for (or changes of) eyeglasses or lenses of any type; eyeglasses, contact lenses, and all fittings, except as otherwise specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible Facility.

...

Local anesthesia charges billed separately by a Practitioner for surgery he or she performed on an Outpatient basis.

...

Private-Duty Nursing, unless You have followed the section of this Policy called "Request For Care Preapproval."

...

Routine Foot Care, except when determined by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
- —for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
- —provided by or in any locale outside the United States*{, except}* ***other than*** in the case of a Medical Emergency***, unless received by a Dependent who is attending an accredited school in a foreign country under the terms stated in the definition of Dependent***;
- —provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
- *{—provided by a social worker, except as otherwise stated in this Policy;}*
- —received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- —rendered prior to Your Effective Date of coverage or after Your termination date of coverage under this Policy;
- —which are specifically limited or excluded elsewhere in this Policy;
- —which are not Medically Necessary and Appropriate; or
- —which You are not legally obligated to pay.

...

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

...

X. [XII.] CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send *{us}* ***Us*** written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

...

Claims Appeal: If We decline Your claim in whole or in part, We will send You an explanation of benefits in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date after We receive Your request for review.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot

bring legal action against this Policy after three years from the date You file proof of loss.

XI. [XIII.] *COORDINATION OF BENEFITS*
{BENEFITS FROM OTHER PLANS}

***This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.**

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action.

When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.*

*{This provision applies to all Covered Charges under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You incur Claims under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount. To the extent You have not paid the full premium amount, We will offset the amount due from any benefit amount payable for Covered Charges.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.}*

[XII. [XIV.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits ***and those amounts were not otherwise deducted from an award, judgement or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97***.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Accidental Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement *{will}* ***shall*** be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment *{in whole or in part}* from a third party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.*{}}*

This provision shall not be construed or applied so as to require the return of any benefits properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable state or federal law and that other law precludes such repayments.]

XII. [XIV.] [XV.] GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will void the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

...

AMENDMENT

The Policy may be amended, at any time, without Your consent or ***that*** of anyone else with a beneficial interest in it. The Policyholder may change tye type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].

(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].

(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.

(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to *{Coverage}* ***coverage*** under this Policy will reduce Your *{Coverage}* ***coverage***. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;

(b) fraud or misrepresentation by You or Your Dependents;

(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;

(d) You become eligible ***either for Medicare, Medicaid, or*** to participate in a Group Health Benefits Plan which provides the same or similar coverage;

(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

...

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

...

[*{NETWORK}* *IN-NETWORK* AND *{NON-NETWORK}* *OUT-OF-NETWORK* PROVIDER REIMBURSEMENT

Payment amounts, as specified in the *"*Schedule of Benefits*"*, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

{A Network} ***An In-Network*** Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by *{a Non-Network}* ***an Out-of-Network*** Provider may be different than our *{Network}* ***In-Network*** Provider Allowance; also, *{a Non-Network}* ***an Out-of-Network*** Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible Facility or Practitioner, We will Determine to pay either You or the Facility or Practitioner.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

...

APPENDIX

EXHIBIT F

This *{Policy}* ***Contract*** has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the HMO health benefits plan.

Notice of Right to Examine *{Policy}* ***Contract***. Within 30 days after delivery of this *{Policy}* ***Contract*** to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The *{Policy}* ***Contract*** will be deemed void from the beginning.

[CARRIER]

HEALTH MAINTENANCE ORGANIZATION BENEFITS PLAN

(New Jersey HMO Health Benefits Plan)

{Policy} ***Contract*** Term. The Policy takes effect on *[*____ *]*, the *{Policy}* ***Contract*** Effective Date. The term of this *{Policy}* ***Contract*** starts on your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid or a Group Health Benefits Plan. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the *{Policy}* ***Contract***.

Renewal Provision. Subject to all *{Policy}* ***Contract*** terms and provisions, including those describing Termination of the *{Policy}* ***Contract***, You may renew and keep this *{Policy}* ***Contract*** in force by paying the Premiums as they become due. We agree to arrange or provide services under the terms and provisions of this *{Policy}* ***Contract***. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the *{Policy}* ***Contract***.

Premiums. We may only change the Premium schedule for this *{Policy}* ***Contract*** if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this HMO Health Benefits Plan.

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I. DEFINITIONS

The words shown below have specific meanings when used in this *{Policy}* ***Contract***. Please read these definitions carefully. Throughout the *{Policy}* ***Contract***, these defined terms appear with their initial letters capitalized. They will help You to understand what services are provided. Information about the services provided under this *{Policy}* ***Contract*** begins on page 22.

...

ANNIVERSARY DATE. The date which is one year from the Effective Date of this *{Policy}* ***Contract*** and each succeeding yearly date thereafter.

[**ASSOCIATED MEDICAL GROUPS.** Any Medical Group with which we contract directly to provide Covered Services to Members including the [ ]].

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer covered by this *{Policy}* ***Contract***.

BIRTHING CENTER. A Facility which mainly provides care and treatment for people during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

It must also:

(a) carry out its stated purpose under all relevant state and local laws; or
(b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

CHILD. Your own issue or Your legally adopted child and, if the child depends on You for most of its support and maintenance, Your stepchild. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this *{Policy}* ***Contract***. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the *{Policyholder}* ***Contractholder*** or the *{Policyholder's}* ***Contractholder's*** Spouse is not a Child for purposes of eligibility for services under this *{Policy}* ***Contract***.

[**COINSURANCE.** The percentage of a Covered Services or Supplies that must be paid by You. Coinsurance does not include Copayments or Non-Covered *{Expenses}* ***Services***.]

CONTRACT. This agreement, [the Contract Schedule] [Your I.D. card,] any riders, amendments or endorsements, and the application signed by You and the Premium schedule.

CONTRACTHOLDER. The Member who purchased this Contract.

CONTRACT TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Contract is renewed each one-year period thereafter.*

COPAYMENT. A specified dollar amount which You must pay for certain Covered Services or Supplies.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this *{Policy}* ***Contract***. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider.
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

Read the entire *{Policy}* ***Contract*** to find out what We limit or exclude.

...

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 19;
  (3) unmarried Child from age 19 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask You to provide periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this *{Policy's}* ***Contract's*** age limit, if:
  (1) the Child remains unmarried and unable to support himself or herself;
  (2) the Child's condition started before the Child reached this *{Policy's}* ***Contract's*** age limit;
  (3) the Child became insured before the Child reached this *{Policy's}* ***Contract's*** age limit, and stayed continuously insured until the Child reached such limit; and
  (4) the Child depends on You for most of *{its}* ***his or her*** support and maintenance.

In order for the Child to remain a Dependent, You must send Us written proof that the Child is handicapped and depends on You for most of its support and maintenance. You have 31 days from the date the Child reaches this *{Policy's}* ***Contract's*** age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who resides in a foreign country. However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.

...

EFFECTIVE DATE. The date on which coverage begins under this *{Policy}* ***Contract*** for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   —The American Medical Association Drug Evaluations;
   —The American Hospital Formulary Service Drug Information; or
   —The United States Pharmacopeia Drug Information.
   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.
   In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. A place *{We are required by law to recognize}* which:
(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this *{Policy}* ***Contract***.

...

[HEALTH CENTER (or HEALTH CARE CENTER)—Any place operated by or on behalf of an HMO where ***a*** [Network] [Participating] ***[Provider] [Practitioner]*** Provides Covered Services and Supplies to Members]

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate ***or reduce*** Hospital stays. *{We will recognize it if it is}* ***The agency must be*** licensed by the state in which it operates, *{or it is}* ***be*** certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. It carries out it***s*** stated purpose under all relevant state and local laws, and it is:
(a) approved for its stated purpose by Medicare;
(b) accredited for its stated purpose by the Joint Commission; or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

HOSPITAL. A Facility which mainly provides Inpatient care for Ill or Accidentally Injured people. It carries out its stated purpose under all relevant state and local laws, and it is:
(a) accredited as a hospital by the Joint Commission,
(b) approved as a *{H}***h***ospital by Medicare or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

Among other things, a Hospital is not a convalescent, rest or nursing home or Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A Facility for the aged or for Substance Abusers or Alcoholics is not a Hospital.

A specialty Facility is also not a Hospital.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care Facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

[**MAINTENANCE DRUG.** A Prescription Drug used for the treatment of *{the following}* chronic medical conditions ***including but not limited to***: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes(oral agents only); glaucoma; hypertension; thyroid disease; seizure disorders.]

. . .

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. ***Medical emergencies include but are not limited to: uncontrolled or excessive bleeding, acute pain or conditions requiring immediate attention such as suspected heart attack, severe shortness of breath or appendicitis*** *{Heart attacks}*, strokes, convulsions, ***severe*** burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness***.*** *{are Medical Emergencies.}* We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

. . .

MEMBER. An eligible person who is covered under this *{Policy}* ***Contract***.

MENTAL HEALTH CENTER. A Facility that provides treatment for people with mental health problems. *{We will recognize such a place if it carries}* ***The Facility must carry*** out its stated purpose under all relevant state and local laws, and *{it is}* ***be***:

(a) accredited for its stated purpose by the Joint Commission;
(b) approved for its stated purpose by Medicare; or
(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental *{and}* ***or*** Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement with Us [or Our Associated Medical Groups] to provide Covered Services or Supplies.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, or which exceed any of the benefit limits shown in this *{Policy}* ***Contract***, or which are specifically identified as Non-Covered *{Expenses}* ***Services***. *{Copayments and Coinsurance are also Non-covered Expenses.}*

[NON- [NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not a [Network] [Participating] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
(b) provides medical services which are within the scope of the nurse's license or certificate and are covered by this *{Policy}* ***Contract***.

OUTPATIENT. You, if You are registered at a recognized health care Facility and not an Inpatient; or services and supplies provided in such a setting.

PRACTITIONER. A person *{[Carrier] is required by law to recognize}* who:

(a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
(b) provides medical services which are within the scope of his or her license or certificate and which are covered by this *{Policy}* ***Contract***.

PARTIAL HOSPITALIZATION. Day treatment services for Mental or Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this *{Policy}* ***Contract***:

(a) as a Dependent or *{Policyholder}* ***Contractholder***; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A Facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

***{POLICY.** This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Member who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.}*

PREMIUM. The periodic charges due under this *{Policy}* ***Contract*** which the *{Policyholder}* ***Contractholder*** must pay to maintain this *{Policy}* ***Contract*** in effect.

. . .

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this *{Policy}* ***Contract*** starts, and for which:

(a) You see a Practitioner, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his ***or her*** coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations. See the exclusions section of this *{Policy}* ***Contract*** for details on how this *{Policy}* ***Contract*** limits the services for Pre-Existing Conditions.

. . .

PREMIUM DUE DATE. The date on which a Premium is due under this *{Policy}* ***Contract***.

. . .

PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a Practitioner specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for OB/GYN services only),] or pediatrics who supervises, coordinates and provides initial care and basic medical services to a Member; initiates a Member's Referral

for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIMARY RESIDENCE. The location where You reside for a majority of the Calendar Year with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intent to return, will not interrupt Your Primary Residence in New Jersey.

PROVIDER. A *{recognized}* Facility or Practitioner of health care.

REFERRAL. Specific direction or instruction from Your Primary Care Physician [or Care Manager] ***[or Health Center]*** or that directs You to a Facility or Provider for health care.

REHABILITATION CENTER. A Facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. It carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; *{or}*

(b) approved for its stated purpose by Medicare*{.}**; **or**

(c) licensed, certified, or accredited by the state in which it operates.*

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, dermatomas, keratosis, onychauxis, onychocryptosis or tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. It carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by the Joint Commission; *{or}*

(b) approved for its stated purpose by Medicare*{.}**; **or**

(c) licensed, certified, or accredited by the state in which it operates.*

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPECIALIST PRACTITIONER. A Practitioner who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

. . .

SPOUSE. An individual legally married to the *{Policyholder}* ***Contractholder*** under the laws of the State of New Jersey.

. . .

SUBSTANCE ABUSE CENTERS. A Facility that mainly provides treatment for Substance Abuse. *{We will recognize such a place if it carries}* ***The Facility must carry*** out its stated purpose under all relevant state and local laws, and *{it is}* ***be***:

(a) accredited for its stated purpose by the Joint Commission;

(b) approved for its stated purpose by Medicare; or

(c) *{accredited or licensed by the state of New Jersey.}* ***licensed, certified, or accredited by the state in which it operates.***

. . .

SURGICAL CENTER. A Facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Practitioners and Nurses, under the supervision of a Practitioner;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

{It} ***(We will recognize it if it)*** carries out its stated purpose under all relevant state and local laws, and it is *{either}*:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; *{or}*

(b) approved for its stated purpose by Medicare*{.}**; **or**

(c) licensed, certified, or accredited by the state in which it operates.*

A Facility is not a Surgical Center if it is part of a Hospital.

. . .

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from an Accidental Injury or Illness:

. . .

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this *{Policy}* ***Contract***. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The *{Policyholder}* ***Contractholder*** and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A *{Policyholder}* ***Contractholder*** who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this *{Policy}* ***Contract*** for the *{Policyholder}* ***Contractholder*** only.

(b) **FAMILY COVERAGE**—coverage under this *{Policy}* ***Contract*** for You and Your Dependent(s).

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this *{Policy}* ***Contract*** for You and all Your Child Dependents or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.

(d) **HUSBAND AND WIFE *COVERAGE***—coverage under this *{Policy}* ***Contract*** for You and Your Spouse.

WHO IS ELIGIBLE

(a) **THE *{POLICYHOLDER}* *CONTRACTHOLDER***—You, if your Primary Residence is in ***the designated service area in*** the State of New Jersey and You are not eligible for a Group Health Benefits Plan ***that provides same or similar coverage***, Medicare or Medicaid.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan ***that provides same or similar coverage***.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan ***that provides same or similar coverage***, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this *{Policy}* ***Contract***.

ADDING DEPENDENTS TO THIS *{POLICY}* *CONTRACT*

(a) **SPOUSE**—You may apply to add Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change *{your}* ***Your*** type of coverage. If *{your}* ***Your*** application is made and submitted to Us within 31 days of Your marriage to Your Spouse, the Spouse will be covered from the date of the Spouse's eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this *{Policy}* ***Contract*** is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Services or Supplies incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single or Husband and Wife Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single or Husband and Wife Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of the Child's eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this *{Policy}* ***Contract***.

III. SCHEDULE OF SERVICES

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS *{POLICY}* *CONTRACT* ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER BENEFIT PERIOD, UNLESS OTHERWISE STATED. BENEFITS ARE PER MEMBER, AND MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

FACILITY BENEFIT—Unlimited days.

COPAYMENTS:

HOSPITAL SERVICES:

INPATIENT—$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Benefit Period.

OUTPATIENT—$15 Copayment/visit

PRACTITIONER SERVICES:

INPATIENT—None

OUTPATIENT—$15 Copayment/visit; no Copayment if any other Copayment applies.

EMERGENCY ROOM—$50 Copayment/visit/Member (credited toward Inpatient *{Admission}* ***admission*** if *{Admission}* ***admission*** occurs within 24 hours as the result of the emergency).

...

NOTE: NO BENEFITS WILL BE PROVIDED IF YOU FAIL TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH YOUR PRIMARY PHYSICIAN, CARE MANAGER OR HEALTH CENTER AS APPLICABLE*. READ THE GENERAL PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS *{POLICY}* *CONTRACT* CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the coverage provided under this *{Policy}* ***Contract*** are ***[shown in the Contract's Schedule of Premium Rates]***:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Husband and Wife ***Coverage*** ..... [$]

We have the right to change any Premium rate set forth ***[*above*]*** at the times and in the manner established by the provision of this *{Policy}* ***Contract*** entitled "Premium Rate Changes."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Member whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Member that was included in the Premiums paid for the two-month period immediately after the date the Member's coverage has ended.

(b) the amount of any claims paid or the value of any services provided to You or to a member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the *{Policy}* ***Contract***. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the *{Policy}* ***Contract*** is in force. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the ***[*Premium Rates and Provisions section of the *{Policy}* ***Contract*] [Contracts Schedule of Premium Rates]***. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the *{Policy}* ***Contract*** is changed:

(1) by amendment of the *{Policy}* ***Contract***; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described in the General Provisions section of this *{Policy}* ***Contract***.

We will give You 30 days written notice when a change in the Premium rates is made.

V. COVERED SERVICES AND SUPPLIES

You are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by *{y}***Y*ou of applicable *{copayments}* ***Copayments*** as stated in the applicable Schedule of *{Benefits}* ***Services***.

(a) **Outpatient Benefits.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by You, or elsewhere upon prior written referral by Your ***[*Primary Care Physician*] [Health Center] or [Care Manager]***:

1. **Office visits** during office hours, and during non-office hours when Medically Necessary ***and Appropriate***.
2. **Home visits** by your Primary Care Physician.
3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and
   e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of your employment).
4. **Diagnostic Services.**
5. **Casts and dressings.**
6. **Ambulance Service** when certified in writing as Medically Necessary ***and Appropriate*** by *{your}* ***Your*** ***[*Primary Care Physician*] [or Care Manager]*** and approved in advance by *{Us}* ***Us [or the Care Manager]***.

...

8. **Prosthetic Devices and Durable Medical Equipment** when ordered by Your Primary Care Physician ***[or Care Manager]*** and arranged through *{us}* ***Us***. We cover

only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.

9. **Prescription Drugs.**

(b) **SPECIALIST PRACTITIONER BENEFITS.** The following Services are covered when rendered by a ***[Network] [*Participating*]*** Specialist Practitioner at the Practitioner's office[, or Health Center] or at a ***[Network] [*Participating*]*** Hospital outpatient department during office or business hours upon prior written referral by *{your}* ***Your*** Primary Care Physician ***[or Care Manager]***. Services include but are not limited to the following:

1. Allergy (except serum injections which are covered when administered by *{your}* ***Your*** Primary Care Physician)

...

(c) **INPATIENT HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a ***[Network] [*Participating*]*** *{Provider}* ***Practitioner*** upon prior written referral from *{your}* ***Your*** Primary Care Physician ***[Care Manager]***, only at ***[Network] [*Participating*]*** Hospitals and ***[Network] [Participating] Practitioners*** *{participating Providers}* (or at ***[Non-Network] [Non-Participating Facilities*** *{non-participating facilities}* upon prior written authorization by *{us}* ***Us***); however, ***[Network] [*Participating*]*** Skilled Nursing Center benefits are limited to those which are Medically Necessary ***and Appropriate*** and which constitute Skilled Nursing Care:

1. Semi-private room and board accommodations
2. Private accommodations will be provided only when Medically Necessary ***and Appropriate*** as certified by *{your}* ***Your*** attending *{physician}* ***Practitioner*** in concurrence with *{your}* ***Your*** Primary Care Physician ***[or Care Manager]*** and approved in advance by Us. If *{you}* ***You*** occupy a private room without such certification *{you}* ***You*** shall be directly liable to the Hospital or Skilled Nursing Center for the difference between payment by Us to the Hospital or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the ***[Network] [*Participating*]*** Hospital or the ***[Network] [*Participating*]*** Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of extensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services
20. Private duty nursing only when Medically Necessary ***and Appropriate*** as certified by the ***[Network] [*Participating*]*** Specialist *{Physician}* ***Practitioner*** or other attending physician in concurrence with *{your}* ***Your*** Primary Care Physician ***[or Care Manager]*** and approved in advance by Us.
21. The following transplants, when Medically Necessary ***and Appropriate***: Cornea, Kidney, Lung, Liver, Heart, Heart-Lung, Heart Valves Pancreas.
22. Allogenic bone marrow transplants.
23. Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma Neuroblastoma, *{Aplastic, Anemia, Genetic Disorders (SCID and WISCOT Alldrich)}* and Breast Cancer when approved in advance by Us, if You are participating in a National Cancer Institute sponsored Clinical trial.

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL *{AND}* *OR* NERVOUS CONDITIONS.** The following Services are covered when rendered by a ***[Network] [*Participating*] Practitioner at Practitioner's*** *{Provider at Provider's}* office[, Health Center] or at a ***[Network]** [* Participating*]* Substance Abuse Center upon prior written referral by *{your}* ***Your*** ***[*Primary Care Physician*] [[or] Care Manager]***.

1. **Outpatient.** You are entitled to receive up to twenty (20) *{outpatient] ***Outpatient*** visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by *{your}* ***Your*** Primary Care Physician ***[or Care Manager]*** for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for nonmedical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by *{your}* ***Your*** Primary Care Physician ***[or Care Manager]*** for up to sixty (60) more *{outpatient}* ***Outpatient*** visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.
2. **Inpatient Hospital Care.** You are entitled to receive up to thirty (30) days of *{inpatient}* ***Inpatient*** care benefits for detoxification, medical treatment for medical conditions resulting from the *{substance abuse}* ***Substance Abuse***, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, *{nurse}* ***Nurse***, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. Repeat Detoxification Treatment. *{Chemical Dependency Admissions.}* Repeated detoxification treatment for chronic *{substance abuse}* ***Substance Abuse*** will not be covered unless in *{our sole discretion}* ***Our Sole Discretion*** it is *{determined}* ***Determined*** that You have been cooperative with an on-going treatment plan developed by a ***[Network** [*Participating *{Provider}* ***Practitioner***. Failure to comply with treatment shall constitute cause for non-coverage of substance abuse services.

{3. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and only to the extent of the covered benefit as defined above.}

Court-ordered Substance Abuse or Mental or Nervous Conditions admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as described below.

(e) **ALCOHOLISM BENEFITS.** The following Services are covered when rendered by a ***[*Participating Provider*] [Network Practitioner]*** at *{Provider's*}* ***Practitioner's*** office[, Health Center] or at a ***[Network]** [*Participating*]* Substance Abuse Center upon prior written referral by *{your}* ***Your*** Primary Care Physician ***[or Care Manager]***.

1. **Outpatient.** You are entitled to receive up to twenty (20) *{outpatient] ***Outpatient*** visits during any period of 365 consecutive days. Benefits include diagnosis, medical treatment and medical referral services by *{your}* ***Your** [*Primary Care Physician*] ***[or Care Manager]*** for the abuse of or addiction to alcohol. Payment for nonmedical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by *{your}* ***Your*** Primary Care Physician ***[or Care Manager]*** for

up to sixty (60) more *{outpatient}* ***Outpatient*** visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** You are entitled to receive up to thirty (30) days of *{inpatient}* ***Inpatient*** care benefits for detoxification, medical treatment for medical conditions resulting from the *{substance abuse}* ***Substance Abuse***, and referral services for *{substance abuse}* ***Substance Abuse*** or addiction. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, *{nurse}* ***Nurse***, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

3. Repeat* Detoxification *{Admissions}* *Treatment. Repeated detoxification treatment for chronic *{alcoholism}* ***Alcoholism*** will not be covered unless in *{our sole discretion}* ***Our Sole Discretion*** it is *{determined}* ***Determined*** that You have been cooperative with an ongoing treatment plan developed by a *[Network [*Participating *{Provider}* ***Practitioner***. Failure to comply with treatment shall constitute cause for non-coverage of *{alcoholism}* ***Alcoholism*** services.

{3.} ***4.*** Court-ordered alcohol admissions are not covered unless Medically Necessary ***and Appropriate*** and only to the extent of the covered benefit as defined above.

(f) **MEDICAL EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by *{your}* ***Your*** Primary Care Physician ***[or Care Manager]*** in the event of *{an}* ***a Medical Emergency*** as *{determined}* ***Determined*** by Us ***[or the Care Manager]***.

1. Your Primary Care Physician ***[or Care Manager]*** is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to *{your}* ***Your*** health, *{you}* ***You*** shall call *{your}* ***Your*** Primary Care Physician ***[or Care Manager]*** [or Health Center] [or Us] prior to seeking ***Medical*** *{emergency}* ***Emergency*** treatment.
2. We will cover the cost of Medical Emergency and ***Medical*** services performed within or outside *{our}* ***Our*** service area without a prior written referral only if:
   a. Our review determines that *{your}* ***Your*** symptoms were severe and delay of treatment would have been detrimental to your health, the symptoms occurred suddenly, and *{you}* ***You*** sought immediate medical attention. *{Conditions which require immediate treatment include, but are not limited to the following:
      1. uncontrolled or excessive bleeding
      2. acute pain or conditions requiring immediate attention, such as suspected heart attack, severe shortness of breath or appendicitis
      3. serious burns
      4. poisoning
      5. convusions
      6. unconsciousness}*

      A near-term delivery is not a Medical Emergency.
   b. The service rendered is provided as a benefit under this *{Policy}* ***Contract*** and is not a service which is normally treated on a non-emergency basis; and
   c. We and *{your}* ***Your*** Primary Care Physician ***[or Care Manager]*** are notified within 48 hours of the ***Medical*** *{emergency}* ***Emergency*** service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the *{emergency}* ***Emergency*** services within 30 days. You shall be responsible for payment of services received unless We *{determine}* ***Determine*** that *{your}* ***Your*** failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event *{you}* ***You*** are hospitalized in a ***[Non-Participating] [Non-Network]*** *{Non-participating}* Facility, coverage will only be provided until *{you}* ***You*** are medically able to travel or to be transported to a ***[Network]*** [*Participating*]* Facility. If *{you}* ***You*** elect to continue treatment with ***[Non-network] [Non-Participating] Providers*** *{Non-participating providers}*, We shall have no responsibility for payment beyond the date *{you}* ***You*** are determined to be medically able to be transported.

   In the event that transportation is Medically Necessary and Appropriate, We will cover the reasonable cost as *{determined}* ***Determined*** by *{us}* ***Us***. Reimbursement may be subject to payment by *{you}* ***You*** of all *{copayments}* ***Copayments*** which would have been required had similar benefits been provided during office hours and upon prior written referral to ***the [Network]*** [*Participating*]* Provider.
4. Coverage for ***Medical*** *{emergency}* ***Emergency*** services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after *{you}* ***You*** have been admitted to a Facility as the result of a Medical Emergency shall require prior written referral or *{you}* ***You*** shall be responsible for payment.
5. The *{copayment}* ***Copayment*** for ***a Medical*** *{an emergency}* ***Emergency*** room visit will not apply in the event that *{you}* ***You*** were referred for such visit by *{your}* ***Your*** Primary Care Physician ***[or Care Manager]*** for services that could have been rendered in the Primary Care Physician's office or if *{you}* ***You*** are admitted as an *{inpatient}* ***Inpatient*** to the *{hospital}* ***Hospital*** as a result of the Medical Emergency.

*{(h)}**(g)* **THERAPY SERVICES.** The following Services are covered when rendered by a ***[Network]***]*Participating*]* Provider upon prior written referral by *{your}* ***Your*** Primary Care Physician.

1. Speech therapy, Physical therapy, *{occupational}* ***Occupational*** therapy and *{cognitive}* ***Cognitive*** therapies are covered for non-chronic conditions and acute Illnesses and Accidental Injuries upon referral to a ***[Network]*** [*Participating*[* Provider by *{your}* ***Your*** Primary Care Physician ***[or Care Manager]***. This benefit consists of treatment for a 60 day period per incident of *{illness}* ***Illness*** or *{injury}* ***Accidental Injury***, beginning with the first day of treatment, provided that *{your}* ***Your*** Primary Care Physician ***[or Care Manager]*** certifies in writing that the treatment will result in a significant improvement of *{your}* ***Your*** condition within this time period and treatment is approved in writing by Us.
2. Chelation therapy, *{chemotherapy}* ***Chemotherapy*** treatment, *{dialysis}* ***Dialysis*** treatment, *{infusion}* ***Infusion*** therapy and *{radiation}* ***Radiation*** therapy.

*{(i)}**(h)* **HOME HEALTH BENEFITS.** The following *{Services}* ***services*** are covered when rendered by a ***[Network]*** [*Participating*]* Provider, including but not limited to a ***[Network]*** [*Participating*]* Home Health Agency, as an alternative to hospitalization and are approved and coordinated in advance by *{us}* ***Us*** upon the prior referral of *{your}* ***Your*** Primary Care Physician ***[or Care Manager]***.

...

1. Skilled nursing services, provided by or under the supervision of a registered professional nurse.
2. Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to *{you}* ***You*** is skilled in nature.
3. Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care

Physician certifies that such services are essential for the effective treatment of *{your}* ***Your*** medical condition.

4. Therapy Services as set forth above.
5. Hospice Care if You are terminally *{ill}* ***Ill*** with life expectancy of six months or less*{.}**,* Services may include home and *{hospital}* ***Hospital*** visits by *{nurses}* ***Nurses*** and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in *{our determination}* ***Our Determination*** the treatment setting is not appropriate, or when there is more cost effective setting in which to provide appropriate care.

VI. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS *{POLICY}* *CONTRACT*.

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not *{medically appropriate,}* ***Medically Necessary and Appropriate.***

Any service provided without prior written Referral by the Member's Primary Care Physician ***[or Care Manager]*** except as specified in this *{Policy}* ***Contract***.

...

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this *{Policy}* ***Contract*** or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

High-dose chemotherapy, except as otherwise stated i this *{Policy}* ***Contract***.

...

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this *{Policy}* ***Contract*** for twelve months. See the "Definitions" section of this *{Policy}* ***Contract*** for the definition of a Pre-Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, *{or}* birth defects in a covered Dependent Child ***or complications of pregnancy as defined in N.J.A.C. 11:1-4.3***. We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan ***delivered or issued for delivery in the United States*** with no intervening lapse in coverage, You have been treated or diagnosed by a *{physician}* ***Practitioner*** for a condition under that plan or satisfied a 12 month preexisting condition limitation ***for a condition covered by that plan***.

...

[Prescription Drugs: We do not cover an initial prescription or refill that exceeds the lesser of: the amount prescribed by the Participating Provider and the amount shown below that applies to the Prescription Drug:

(a) For a Prescription Drug which is an oral contraceptive drug or a Maintenance Drug: a ninety (90) day supply.
(b) For all other Prescription Drugs:
  (i) a thirty (30) day supply of tablets, capsules, and liquids to be taken orally; or
  (ii) sixty (60) milliliters or one (1) manufacturer's smallest standard package size of topical solution or lotion;
  (iii) a fourteen (14) day supply of rectal or vaginal medication (e.g., suppositories, creams, ointment, enemas, etc.); or
  (iv) one (1) manufacturer's standard package unit containing no more than sixty (60) grams of topical ointment or cream; or
  (v) one (1) vial containing no more than fifteen (15) milliliters of any otic or opthalmic product; or
  (vi) two (2) manufacturer's smallest standard package units of a nasal or oral inhaler; or
  (vii) three (3) manufacturer's standard (10) milliliter vials of insulin.

We also do not cover prescription refills that are:

(a) dispensed more than 12 months after the day of the Provider's original order of the Prescription Drugs; or
(b) dispensed more than 10 days before the date the prior prescription or refill would be consumed when taken as directed.

A Prescription Drug that is prescribed for injectable use, other than injectable insulin on prescription only, is not covered.

Allergy and biological sera, therapeutic devices or appliances are not covered as Prescription Drugs.]

Private-Duty Nursing, except as provided for under Home Health Care.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine Foot Care except when determined by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

—eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
—for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
—for which You would not have been charged if You did not have health care coverage;
—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—needed because You committed or tried to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service *{medical emergency}* ***Medical Emergency***; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or ***(c) provided in a hospital that*** *{the hospital}* is located outside of the United States and Puerto Rico; or ***(d) We are required by law to cover*** *{unless otherwise required by law}*.
—provided by or in any locale outside the United States, *{except}* ***other than*** in the case of a Medical Emergency ***unless received by a Dependent who is attending an accredited school in a foreign country, under the terms stated in the definition of Dependent***;
—provided by a licensed pastoral counselor in the course of his or her normal duties as a pastor or minister;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after your termination date of coverage under this *{Policy}* ***Contract***;
—which are specifically limited or excluded elsewhere in this *{Policy}* ***Contract***;
—which are not Medically Necessary and Appropriate;
{—due to an Accidental Injury or Illness}
—for which You are not legally obligated to pay.

...

Transportation; travel.

...

VII. GRIEVANCE PROCEDURE

[Grievance Procedure: Variable by Carrier as approved by the State of New Jersey.]

VIII. *COORDINATION OF BENEFITS* *{BENEFITS FROM OTHER PLANS}*

SERVICES AVAILABLE UNDER OTHER POLICIES

***If Covered Services are provided under this Policy and these same Covered Services or expenses are covered under Other Valid Coverage,**

Our liability will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our liability on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Services) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Services) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the reasonable cash value of the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on an individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.*

*{This provision applies to all Covered Services and Supplies under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges or provides Covered Services and Supplies first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You receive Covered Services and Supplies under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.}*

IX. RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person ***receives services or supplies from Us or*** makes a claim to Us for benefits under this *{Policy}* ***Contract*** prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits ***or arranged [or provided] services or supplies and those amounts were not otherwise deducted from an award, judgment or settlement in a civil action, brought in a court of this State, pursuant to N.J.S.A. 2A:15-97***.

The repayment will be equal to the amount of benefits paid by Us ***or the reasonable cash value of services and supplies arranged or provided by Us***. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid ***or the reasonable cash value of all services and supplies arranged [or provided]*** for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Accidental Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement *{will}* ***shall*** be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this *{Policy}* ***Contract or arrange [or provide] services and supplies*** to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no-fault tort liability of a Third Party.

This provision shall not be construed or applied so as to require the return of any benefit properly paid by an insurer or entity other than Us where the payment of those benefits was made pursuant to some other applicable state or federal law and that other law precludes such repayment.

X. GENERAL PROVISIONS

AMENDMENT

The *{Policy}* ***Contract*** may be amended, at any time, without Your consent or that of anyone else with a beneficial interest in it. The *{Policyholder}* ***Contractholder*** may change the type of coverage under this *{Policy}* ***Contract*** at any time by notifying Us in writing.

We may make amendments to the *{Policy}* ***Contract*** upon 30 days' notice to the *{Policyholder}* ***Contractholder***, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this *{Policy}* ***Contract*** will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the *{Policy}* ***Contract***, to extend the time in which a Premium may be paid, to make or change a *{Policy}* ***Contract***, or to bind Us by a promise or representation or by information given or received.

No change in the *{Policy}* ***Contract*** is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].

(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the *{Policy}* ***Contract*** as provided in the section of this *{Policy}* ***Contract*** called "Conformity With Law," it is shown in an amendment to it that is signed by an office of [Carrier].

(c) if a change is required by [Carrier], it is accepted by the *{Policyholder}* ***Contractholder***, as evidenced by payment of a Premium on or after the effective date of such change.

(d) if a written request for a change is made by the *{Policyholder}* ***Contractholder***,it is shown in an amendment to it signed by the *{Policyholder}* ***Contractholder*** or by an officer of [Carrier].

ASSIGNMENT

No assignment of transfer by You of any of Your interest under this *{Policy}* ***Contract*** is valid unless We consent thereto.

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this *{Policy}* ***Contract*** will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made. premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate Your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this *{Policy}* ***Contract***.

CONFIDENTIALITY

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the phyisician-patient relationship or hospital-patient relationship shall be kept confidential by us or *{as may otherwise be provided by law}*; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this *{Policy}* ***Contract*** or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us ***or as may otherwise be provided by law*** may not be disclosed without the Member's written consent.

CONFORMITY WITH LAW

If the provisions of the *{Policy}* ***Contract*** do not conform to the requirements of any state or federal law that applies to the *{Policy}* ***Contract***, the *{Policy}* ***Contract*** is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

CONTINUATION OF COVERAGE

If you die while this *{Policy}* ***Contract*** is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this *{Policy}* ***Contract*** for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the *{Policy}* ***Contract*** provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this *{Policy}* ***Contract***.

CONVERSION PRIVILEGE

If your Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this *{Policy}* ***Contract*** ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this *{Policy}* ***Contract*** will apply under the new coverage to the extent it remains unsatisfied.

GOVERNING LAW

This entire *{Policy}* ***Contract*** is governed by the laws of the State of New Jersey.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this *{Policy}* ***Contract*** is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this *{Policy}* ***Contract***, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the *{Policyholder}* ***Contractholder***, coverage may be terminated for the *{Policyholder}* ***Contractholder*** as well as any of the *{Policyholder's}* ***Contractholder's*** Dependents who are Members. To be eligible for services or benefits under this *{Policy}* ***Contract***, the holder of the card must be a Member on whose behalf all applicable premium charges under this *{Policy}* ***Contract*** have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this *{Policy}* ***Contract*** shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any othe person, such card may be retained by *{us}* ***Us***, and all rights of such Member and his or her Dependents, if any, pursuant to this *{Policy}* ***Contract*** shall be terminated immediately, subject to the Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our ***[Network]*** [*Participating*]* Providers or entities with whom We have arranged for services under this *{Policy}* ***Contract***, or similar causes, the rendition of medical or hospital benefits or other services provided under this *{Policy}* ***Contract*** is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid *{premiums}* ***Premiums*** held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provisions of services, taking into account the impact of the event.

INCONTESTABILITY OF THE *{POLICY}* *CONTRACT*

There will be no contest of the validity of the *{Policy}* ***Contract*** except for not paying *{premiums}* ***Premiums***, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your *{insurance}* ***coverage*** or in denying a claim for *{a loss incurred}* ***benefits*** after such *{insurance}* ***coverage*** has been in force for two years during Your lifetime.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No Participating Provider or other provider, institution, Facility or agency is our agent or employee. Neither HMO nor any employee of HMO is an agent or employee of any Participating Provider or other provider, institution, Facility or agency.
2. Neither the *{Policyholder}* ***Contractholder*** nor any Member is our agent, representative or employee, or an agent or representative of any ***Contract*** Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this *{Policy}* ***Contract***.
3. ***Contract*** Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.
4. No *{Policyholder}* ***Contractholder*** or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by a duly authorized officer of HMO.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the *{policy}* ***contract*** until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

LIMITATION ON SERVICES

Except in cases of Medical Emergency, services are available only from ***[Network]*** [*Participating*]* Providers. HMO shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by *{us}* ***Us***.

MEDICAL NECESSITY

Members will receive designated benefits under the Policy only when Medically Necessary and Appropriate, We may determine whether any benefit provided under the Policy was Medically Necessary and Appropriate, and We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity and appropriateness are subject to review by the Quality Assessment Committee of HMO or its physician designee. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Policy that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under this Policy.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the *{Policy}* ***Contract*** may be sent by United States *{Mail}* ***mail***, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in this *{Policy}* ***Contract***, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this *{Policy}* ***Contract***.

We reserve the right to modify or replace an erroneously issued *{Policy}* ***Contract***.

Information in Your application may not be used by Us to void this *{Policy}* ***Contract*** or in any legal action unless the application or a duplicate of it is attached to this *{Policy}* ***Contract*** or has been furnished to You for attachment to this *{Policy}* ***Contract***.

***{POLICY}* *CONTRACT* INTERPRETATION**

We shall administer *{Policy}* ***Contract*** in accordance with its terms and shall have the sole power to *{determine}* ***Determine*** all questions arising in connection with its administration, interpretation and application.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey within our authorized Service Area. We reserve the right to require proof of Your Primary Residence.

We will cancel this *{Policy}* ***Contract*** if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

REFERRAL FORMS

You can be referred for Specialist Services by Your Primary Care Physician ***[or Care Manager]***.

You will be responsbile for the cost of all services provided by anyone other than Your Primary Care Physician (including but not limited to Specialist Services) if You have not been referred by Your Primary Care Physician ***[or Care Manager]***.

. . .

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT

A Member has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A Member has the right to participate in decision-making regarding the Member's care. Further, a Member may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a Participating Physician. A Member who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another Participating Physician. If such Participating Physician(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the Participating Physician shall inform the Member of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the Member and or the Member's family or other person acting on the Member's behalf. If the Member refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the Member in writing that We will not provide further benefits or services for the particular condition or its consequences. The Member's decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Grievance Procedure and We will continue to provide all benefits covered by the *{Policy}* ***Contract*** during the pendency of the Grievance Procedure. We reserve the right to expedite the Grievance Procedure. If the Grievance Procedure results in a decision upholding position of the Participating Physician(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this *{Policy}* ***Contract*** for treatment of such condition or its consequences unless the Member asks, in writing and within 7 days of being informed of the result of the Grievance Procedure, to terminate this *{Policy}* ***Contract*** in accordance with Section IX. In such event, We will continue to provide all benefits covered by this *{Policy}* ***Contract*** for 30 days or until the date of termination, whichever comes first, and We and the Participating Physician will cooperate with the Member in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT

A Member has the right under New Jersey law to refuse life sustaining treatment. A Member who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with this *{Policy}* ***Contract***. We will follow a Member's properly executed advance directive or other valid indication of refusal of life sustaining treatment.

. . .

REPORTS AND RECORDS

HMO is entitled to receive from any provider of services to ***Contract*** Member such information HMO deems to administer this *{Policy}* ***Contract*** subject to all applicable confidentiality requirements as defined in this *{Policy}* ***Contract***. By accepting coverage under this *{Policy}* ***Contract***, *{Policyholder}* ***Contractholder***, for the *{Policyholder}* ***Contractholder***, and for all Dependents covered hereunder, authorizes each and every *{provider}* ***Practitioner*** who renders services to Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and medical condition of Member and render reports pertaining to same to Us upon request and to permit copying of Member's records by Us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When You first obtain this coverage, You and each of Your Dependents must select a Primary Care Physician and***/or*** a Health Center].

You select a Primary Care Physician from Our Practitioners Directory; this choice is solely Yours. However, We cannot guarantee the availability of a particular Practitioner. If the Primary Care Physician initially selected cannot accept additional patients, You will be notified and given an opportunity to make another Primary Care Physician selection.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance *{Policy] ***policy***, You have two options under the terms of Your motor vehicle insurance *{Policy}* ***policy***. The option You select will also determine coverage of any family member covered under that *{Policy}* ***policy*** who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance *{Policy}* ***policy*** (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance *{Policy}* ***policy*** or under similar provisions of a motor vehicle *{Policy}* ***policy*** required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this *{Policy}* ***Contract***.

If You choose this option, We will provide benefits for any Covered *{Charges}* ***Services and Supplies*** incurred for the diagnosis or treatment of an Accidental Injury or Illness result-

ing from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this *{Policy}* ***Contract***.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primary between the motor vehicle insurance policy and this *{Policy}* ***Contract***, this *{Policy}* ***Contract*** will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

STATEMENTS

No statement will void the coverage, or be used in defense of a claim under this *{Policy}* ***Contract***, unless it is contained in writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE

If you fail to pay the cost of Dependent coverage,Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Dependent at 12:01 a.m. on the date the Dependent loses eligibility.

Also, Dependent coverage ends when the *{Policyholder's}* ***Contractholder's*** coverage ends.

Read this *{Policy}* ***Contract*** carefully if Dependnet coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

TERMINATION OF THE *{POLICY}* *CONTRACT*—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the *{Policy}* ***Contract*** will end when that period ends. But You may write to Us, in advance, to ask that the *{Policy}* ***Contract*** be terminated at the end of any period for which Premiums have been paid. Then the *{Policy}* ***Contract*** will end on the date requested.

This *{Policy}* ***Contract*** will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility;
(d) You become eligible ***either for Medicare, Medicaid or*** to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

THE *{POLICY}* *CONTRACT*

The entire *{Policy}* ***Contract*** consists of:

(a) the forms shown in the Tables of Contents as of the Effective Date;
(b) the *{Policyholder's}* ***Contractholder's*** application, a copy of which is attached to the *{Policy}* ***Contract***;
(c) any riders, endorsements or amendments to the *{Policy}* ***Contract***; and
(d) the individual applications, if any, of all Members.

THE ROLE OF YOUR PRIMARY CARE PHYSICIAN

Your Primary Care Physician provides basic health maintenance services and coordinates Your overall health care. Anytime You need medical care, contact Your Primary Care Physician and identify Yourself as a Member of this program.

In a Medical Emergency, You may go directly to the emergency room. If you do, then call Your Primary Care Physician and Member Services within 48 hours. If You do not call within 48 hours, We will cover services only if we Determine that notice was given as soon as was reasonably possible.

[THE ROLE OF THE CARE MANAGER. The Care Manager will manage Your treatment for a ***[*Mental or Nervous *{Disorder}* ***Condition***, Substance Abuse, or Alcoholism.*]* You must contact the Care Manager or Your Primary Care Physician when You need treatment for one of these conditions.]

EXHIBIT M

PPO STANDARD PLAN PROVISIONS

[III. PREFERRED PROVIDER ORGANIZATION PROVISIONS

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. [In addition to an identification card,] the Covered Person will periodically be given up-to-date lists of [XYZ Health Care] Network Providers.

Use of the network is strictly voluntary, but We generally pay a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if a*[*n*]* [XYZ Health Care] Network Provider orders the services and supplies). Of course, a Covered Person is always free to be treated *{by any Provider}* by any Provider or Facility. And, he or she is free to change Providers or Facilities at any time.

A Covered Person may use any [XYZ Health Care] Network Provider. [He or she just presents his or her XYZ Health Care Network identification card to the XYZ Health Care Network Provider or Facility furnishing covered services or supplies. Most XYZ Health Care Network Providers and Facilities will prepare any necessary claim forms for him or her, and submit the forms to Carrier.] The Covered Person will receive an explanation of any insurance payments made by this Policy. [And if there is any balance due, the [XYZ Health Care] Network Provider or Facility will bill You.]

This Policy also has utilization review features. See the *"*Utilization Review*"* section for details.

What We pay is subject to all the terms of this Policy. You should read this policy carefully and keep it available when consulting a Provider.

See the Schedule of Benefits for specific benefit levels, payment rates and payment limits.

If You have any questions after reading this Policy, You should call Us [Claim Office at the number shown on your identification card.]

EXHIBIT N

POS STANDARD PLAN PROVISIONS

***[*III. POINT OF SERVICE PROVISIONS**

A. Definitions

Primary Care *{Practitioner}* *Physician* (PCP) means the *{Practitioner}* ***Physician*** the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization*.* We will supply a list of [PCPs] who are members of the [XYZ] Provider Organization to You.

Provider Organization (PO) means a network of health care Providers located in a Covered Person's Service Area.

***In-*Network Benefits** means the benefits shown in the Schedule which are provided if the [Primary Care Practitioner] provides care, treatment, services, or supplies to the Covered Person or if the [Primary Care Practitioner] refers the Covered Person to another Provider for such care, treatment, services, or supplies.

Out-of-Network Benefits means the benefits shown in the Schedule of Benefits which are provided in the [Primary Care Practitioner] does not authorize the care, treatment, services, and supplies.

Service Area—means the geographical area which is served by the Practitioner in the [XYZ] Provider Organization.

B. Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ] Provider Organization. This policy requires that the Covered Person uses the services of a [PCP], or be referred for services by a [PCP], in order to receive Network Benefits.

C. The [Primary Care *{Practitioner}* *Physician* (PCP)]

The [PCP] will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The [PCP] must authorize all services and

supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized referral form from his or her [PCP] before he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the covered Person does not comply with these requirements, he or she may only be eligible for Out-of-Network Benefits.

We provide *In-*Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her [PCP]. We pay Out-of-Network Benefits when covered services and supplies are not authorized by the [PCP]. If services or supplies are obtained from [XYZ] Providers but they are not authorized by the [PCP], the Covered Person may only be eligible for Out-of-Network Benefits.

A Covered Person may change his or her [PCP] to another [PCP] [once per month]. He or she may select another [PCP] from the list of Practitioner's and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a [PCP], he or she must present his or her ID card and pay the Copayment. When a Covered Person's [PCP] refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.[PCP]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her [PCP]. She must obtain authorization from her [PCP] for any services beyond a routine exam and tests.]

D. Out-of-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her [PCP], he or she will not be eligible for *the In-*Network *Level of* Benefits. For services which have not been referred by the Covered Person's [PCP], whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out-of-Network Benefits.

E. Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her [PCP *or Us*] within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Copayment, and such visits must be retrospectively reviewed [by the [PCP]]. We will waive the emergency room Copayment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the [PCP *or We*] must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

F. Utilization Review

This Policy has utilization review features. See the *"*Utilization Review*"* section of this Policy.

G. Benefits

The *"*Schedule *of Benefits"* shows Network Benefits, Out-of-Network Benefits, and Copayments applicable to the Point of Service arrangement.

What We pay is subject to all the terms of this Policy.*]*

For **Continued Confinement** as an Inpatient beyond the time authorized, You or Your Provider must contact us within hours prior to the preapproved discharge date for additional authorization.

EXHIBIT O

PPO/POS SCHEDULE

Example Schedule of Benefits for Plan A when offered as a PPO/POS

[III. SCHEDULE OF BENEFITS

Services and Supplies provided by a [Primary Care Physician] [Network Provider] [or through a Referral by Your Primary Care Physician/ Network Provider*/Care Manager*] are paid at the In-Network level of benefits.

Payment under this Policy will be provided at the Out-of-Network level of benefits if [Your] [Primary Care Physician] [Network Provider] *[Care Manager]* [has not provided or coordinated Your Care before a Covered Charge is incurred].

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY [ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND] ARE [IS] DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED LIFETIME MAXIMUM *UNLESS OTHERWISE STATED*.

FACILITY BENEFIT—30 days Inpatient Hospital care.

In-Network	[ ]
Out-of-Network	[ ]

COINSURANCE:

FACILITY

In-Network	[ ]
Out-of-Network	[ ]

PRACTITIONER'S SERVICES

In-Network	[ ]
Out-of-Network	[ ]

NOTE: The Coinsurance Amounts cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Copayments

CASH DEDUCTIBLES:

INPATIENT (separate)—$250/day, $1,250 per Period of Confinement/Covered Person; max. of two Inpatient Deductibles/Covered Person.

In-Network	[ ]
Out-of-Network	[ ]

OTHER COVERED CHARGES—$250/Covered Person, $500/family.

In-Network	[ ]
Out-of-Network	[ ]

PRIMARY CARE SERVICES—$100/Covered Person, $300/family. Not subject to Deductibles and Coinsurance.

In-Network	[ ]
Out-of-Network	[ ]

[OTHER—LIST]

In-Network	[ ]
Out-of-Network	[ ]

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

EXHIBIT P

PPO/POS SCHEDULE

Example Schedule of Benefits for Plan B through E when offered as a PPO/POS

[III. SCHEDULE OF BENEFITS

Services and Supplies provided by a [Primary Care Physician] [Network Provider] [or through a Referral by Your Primary Care Physician/ Network Provider*/Care Manager*] are paid at the In-Network level of benefits.

Payment under this Policy will be provided at the Out-of-Network level of benefits if [Your] [Primary Care Physician] [Network Provider] *[Care Manager]* [has not provided or coordinated Your Care before a Covered Charge is incurred].

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY [ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND] ARE [IS] DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO [AN UNLIMITED (PLANS C-E)] [$1,000,000 (PLAN B)] PER LIFETIME MAXIMUM *UNLESS OTHERWISE STATED*.

FACILITY BENEFIT—365 days Inpatient Hospital care.
In-Network [ ]
Out-of-Network [ ]

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE
In-Network [ ]
Out-of-Network [ ]

OTHER COVERED CHARGES
In-Network [ ]
Out-of-Network [ ]

COINSURANCE CAP—[Insert Appropriate Plan Amounts per Covered Person and per Family]

NOTE: The Coinsurance Caps cannot be met with:
- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Copayments

CASH DEDUCTIBLE—[Insert Appropriate Plan Amounts/Covered Person]
[Insert Appropriate Plan Amounts/family]

EMERGENCY ROOM COPAYMENT (Credited toward Inpatient admission if admission occurs within 24 hours as the result of the Medical Emergency)
In-Network [ ]
Out-of-Network [ ]

HOME HEALTH CARE—Unlimited days, if preapproved.
In-Network [ ]
Out-of-Network [ ]

HOSPICE CARE—Unlimited days, if preapproved.
In-Network [ ]
Out-of-Network [ ]

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

BENEFIT MAXIMUMS—Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.
In-Network [ ]
Out-of-Network [ ]

PRESCRIPTION DRUGS—Subject to annual deductible and coinsurance.
In-Network [ ]
Out-of-Network [ ]

PRIMARY CARE SERVICES
In-Network [ ]
Out-of-Network [ ]

SKILLED NURSING CARE
In-Network [ ]
Out-of-Network [ ]

THERAPEUTIC MANIPULATIONS—30 visits/Covered Person.
In-Network [ ]
Out-of-Network [ ]

THERAPY SERVICES—30 visits/Covered Person/Therapy Services except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).
In-Network [ ]
Out-of-Network [ ]

[OTHER—LIST]
In-Network [ ]
Out-of-Network [ ]

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

PUBLIC NOTICES

ENVIRONMENTAL PROTECTION
(a)

TOXIC CATASTROPHE PREVENTION ACT (TCPA) PROGRAM

Notice of Availability of Annual TCPA Fee Schedule Report for Fiscal Year (FY) 1995 pursuant to N.J.A.C. 7:31-2.16(c)8

Take notice that the Department of Environmental Protection is adjusting fees to registrants under the Toxic Catastrophe Prevention Act pursuant to N.J.A.C. 7:31-2.16(c)8, as adopted June 18, 1993. The Department continues to re-examine its fee-setting process in consultation with a Public Advisory Task Force which examines several issues related to the TCPA rule and to assess the impact of the Accidental Release Prevention provisions of the federal Clean Air Act Amendments of 1990 on New Jersey Industry.

The current fees are based on a projected annual budget of $1,957,000, $110,000 less than the prior year. The annually adjusted facility-derived and base fee unit rates, calculated in accordance with N.J.A.C. 7:31-2.16(c)1 through 7, operative during FY 1995 are as follows:

Base fee unit rate	$5,000
Facility derived fee unit rate	$3,600

The inventory derived fee unit rate is established at $10 per hazard unit at N.J.A.C. 7:31-2.16(l)1 through 3. A registrant with a site hosting a single facility and a single hazard unit will be billed an Annual TCPA fee for FY 1995 of $8,610, determined as follows:

Base fee	$5,000
Facility-derived fee	3,600
Inventory-derived fee	10
	$8,610

The values of adopted annually adjusted fee unit rates differ from the values adopted by the Department for FY 1994. In the annual Fee Schedule Report for FY 1994 the Department adopted annually adjusted unit fee rates which compare with those adopted here as follows:

	Base unit fee rate	Facility-derived unit fee rate
Adopted FY 1994	$4,400	$3,400
Adopted FY 1995	$5,000	$3,600

The increase in annually adjusted unit fee rates is modest because of Department efforts to reduce the cost of the TCPA program as the census of regulated sites and facilities declines. The cost reduction was achieved primarily by reduction in staff.

The Department, during the month of January 1995, will send each registrant a bill stating the fee for FY 1995 which shall reflect the number of units of facilities and inventory of extraordinarily hazardous substances at the registrant site, pursuant to N.J.A.C. 7:31-2.16(g). The registrant shall pay its fee by check or money order, payable to "Treasurer, State of New Jersey" prior to February 28, 1995. The check or money order shall be submitted to:

New Jersey Department of Environmental Protection
Bureau of Revenue
Division of Financial Management,
Planning and General Services
CN 417
Trenton, New Jersey 08625

The Annual TCPA Fee Schedule Report detailing the calculations and inputs regarding number of TCPA registrants and facilities, EHS inventories and TCPA spending plan (budget) is available from the Department. Interested persons should contact the Department for a copy of the report at the following address:

Chief, Bureau of Release Prevention
New Jersey Department of Environmental Protection
Division of Environmental Safety,
Health and Analytical Programs
CN 424
Trenton, New Jersey 08625

The Department will mail a copy of this report to all current TCPA registrants.

HUMAN SERVICES
(b)

DIVISION OF YOUTH AND FAMILY SERVICES

Notice of Availability of Federal and State Funds Privatization of Five DYFS-Operated Child Care Centers

Take notice that, in compliance with N.J.S.A. 52:14-34.4, 34.5 and 34.6, the Department of Human Services announces the following availability of funds:

Name of grant program: Privatization of Five DYFS-operated Child Care Centers.

Purpose for which the grant program funds shall be used: The intent of these initiative funds is to privatize the operation of these programs and provide child care services and family support services to the types of children (that is, infant/toddlers, pre-school and before or after kindergarten) referred by the DYFS District Offices, Adoption Resource Centers and the community. The total operating capacity of these five centers—to serve a maximum of 498 children on any given day—will be maintained through subsequent referrals from the DYFS District Offices, Adoption Resource Centers and the community. The majority of these child serving spaces (332 of the 498), are strictly earmarked for children under DYFS supervision.

The five centers to be privatized, as well as their city and county locations, are: Bergen Hill (Jersey City in Hudson County), 5th Street—formerly Jersey Avenue (Jersey City in Hudson County), Evergreen (East Orange in Essex County), Trenton (Trenton in Mercer County) and Neptune (Neptune in Monmouth County).

These programs offer child care and developmental services to children and, with the exception of the 5th Street (formerly Jersey Avenue) Child Care Center and the non-DYFS children at Bergen Hill Child Care Center not enrolled in the Before or After Kindergarten program, also provide transportation and a variety of family support services through linkages with local community programs. The centers are open for services five days a week, 10 hours a day, with children attending the program for at least six hours daily. The child care component of these programs consists of:

- Pre-school educational activities, especially those focusing on verbal communication skills;
- Age-appropriate recreational activities;
- Nutritional services in accordance with the Child and Adult Food Program administered by the State Department of Education;
- Bilingual/Bicultural services, activities and events that reflect the cultural diversity of the catchment area served by the center; and
- Transportation services for the children enrolled (except for the non-DYFS children at the Bergen Hill Child Care Center not enrolled in the Before or After Kindergarten program and the 5th Street—formerly Jersey Avenue—Child Care Center).

The centers also provide support services—either at the center sites or in community-based settings, such as hospital clinics, to which the children are transported. The array of support services provided include:

- Speech therapy to screen and treat children with speech delays and disorders;
- Early intervention and pre-school handicapped programs to address developmental delays;
- Parent support groups;
- Vision, hearing and lead poisoning screening, as well as follow-up treatment, if needed; and
- Intergenerational programs, through the Foster Grandparent or other senior volunteer programs or local Senior Citizens' Groups, which address parenting education and arrange joint activities between the children and parents.

Amount of available funding: Selected providers will be reimbursed in accordance with DYFS Policy Circular 3.50, Child Care Service Contracting, and the terms or conditions listed below to ensure for consistency in the provision of services described within the context of this announcement:

- The initial award will cover the period July 1, 1995 through June 30, 1996—consistent with the contractor(s) assuming operational responsibility for the program(s) on July 1, 1995.
- Funds awarded to all selected providers will be recurring and shall equal the annualized amount of the allocation, contingent upon the provider's compliance with applicable federal and state rules and regulations and the quality and level of services provided, as measured by DYFS.
- Selected applicants will be reimbursed for operating a full-time child care program on the basis of a day care day (10 hours per day). Selected applicants will be required to provide the child care components currently available at each of the sites. These components, as well as the number and ages of children served, are specified below. Any change in the components of children served is contingent upon a request being made to and the prior approval of the Division of Youth and Family Services. The rate of reimbursement (excluding transportation) may not exceed the prevailing **maximum** weekly rates established by the Department of Human Services (DHS), less the child care providers' assessed parental co-payments applicable to the contract service component. Selected applicants will be expected to assess parental co-payments (fees) for child care services in accordance with the DHS fee policy. Maximum weekly child care rates established by the Department of Human Services are listed below:

—Preschool Care:	$99.70 per child per week;
—Infant/Toddler Care:	$120.90 per child per week;
—Before or After Kindergarten:	$49.85 per child per week;
—Summer Care for Before or After Kindergarten:	$99.70 per child per week

The maximum reimbursement rate (excluding transportation) from the State will be the above rates adjusted (that is, reduced) by the assessed parental co-payment (fees). The parental co-payment (fees) are retained by the provider, with the result that the **total** funding available to the provider per child is equal to the respective maximum weekly rate noted above.

For example, for a preschool child, whose parent is assessed a weekly co-payment (fee) of $5.00, the reimbursement rate from DYFS would be $94.70 (plus the per child per week transportation allowance, if applicable). When combined with the parental co-payment (fee), the provider's total weekly revenue for this child would be $99.70 (plus the transportation allowance, if applicable).

Note that providers will be expected to assess and make every effort to collect child care co-payments. However, in the event of non-payment of the assessed co-payment by the parents of a child under DYFS supervision, the Division will reimburse the provider for the unpaid amount. For the two centers that also serve a number of non-DYFS children, the Division will not reimburse providers for the non-payment of fees by the parents of a child **not** under DYFS supervision.

- Selected applicants will be reimbursed by DYFS for the provision of transportation services in these five centers; these services will be provided either directly by the provider or through a sub-contract with a private transportation vendor. Reimbursement will be made on the basis of a **maximum** weekly rate of $24.00 **per child** to include the transportation of children under DYFS supervision and, as warranted, members of their families, to and from the child care center and the child's residence and, when necessary, to community-based settings for support services. In those centers where non-DYFS children are served, DYFS will not provide this transportation allowance for transporting children who are not under DYFS supervision with the exception of those children enrolled in the Before or After Kindergarten program at the Bergen Hill Child Care Center (see below).

DYFS will **not** provide funds for transportation services for the children attending the 5th Street (formerly Jersey Avenue) Child Care Center because most enrollees are community children not under the direct supervision of DYFS and, thus, there are no transportation services currently being provided at this center. Therefore, DYFS will **not** provide funds for the provision of transportation services at this center.

DYFS will **not** provide funds for transportation services for the non-DYFS children at the Bergen Hill Child Care Centers with the exception of those non-DYFS children who are enrolled in the Before or After Kindergarten program. The non-DYFS children in the Before or After Kindergarten program are transported either to their kindergarten program from the Bergen Hill Child Care Center, or from their kindergarten program to the Bergen Hill Child Care Center. The children attending the child care center after kindergarten are then transported home by their parents while those served at the child care center before kindergarten are transported by their parents to the center. Since the center is only responsible for one-way transportation, reimbursement for transportation for the non-DYFS children in the Before or After Kindergarten program will be made on the basis of a **maximum** weekly rate of $14.00 **per child**.

- DYFS is **requiring** the applicants selected to operate the Bergen Hill, Neptune, 5th Street (formerly Jersey Avenue) and Trenton Child Care Centers to remain in the current site locations. The remaining center to be privatized—Evergreen Child Care Center—may remain in its current location or be relocated to a different site, as specified in the Request for Proposals (RFP).

For the Evergreen Child Care Center, non-recurring (one-time-only) funds, above the amount to be reimbursed to the provider for direct child care and, as applicable, transportation services, will be provided by DYFS to cover expenditures (that is, moving costs) related to relocating, as applicable, as well as, one-time-only funds for the replacement of any major institutional appliances such as a range (including the ranges' fire suppression system), refrigerator, dishwasher and freezer that cannot be relocated. The decision on whether to replace any equipment will be made by DYFS. If DYFS agrees that any major appliances must be replaced, DYFS has established the following maximum **per site** amounts for moving costs and appliance replacements:

• moving costs:	$4,000
• institutional range:	$8,600
• range hood with fire suppression system:	$8,000
• institutional refrigerator:	$4,000
• institutional freezer:	$4,000
• institutional dishwasher:	$3,500

Applicants should include in their proposal any requests for such funding.

- The child care equipment (equipment and furniture used in direct child care service delivery) at each of the five sites will be made available to the selected applicant. The equipment accepted by the selected applicant will be incorporated into the contract with DYFS. The selected applicant will be responsible for the maintenance and replacement of any of the acquired equipment. Applicants should include in their proposal a listing of the child care equipment they wish to acquire.
- The obligation of DYFS to implement the terms of this RFP and the resulting contracts is contingent upon the availability of appropriated funds from which payment for contract purposes can be made. No legal responsibility on the part of DYFS for payment shall be made unless and until funds are made available to DYFS from the Legislature and incorporated in the DYFS budget for this purpose.
- DYFS assumes no responsibility or liability for the costs incurred by an applicant for planning or preparing a proposal in response to this announcement.

The funding allotments for each site, excluding any adjustments for rental prepayments, will be based upon the current operational capacity and the program components of the center, as follows:

• 5th Street:	56 Pre-School (no transportation)
• Trenton:	56 Pre-School
• Bergen Hill:	172 Pre-School (no transportation for 26 of the child-saving slots) 66 Infant/Toddler (no transportation for 26 of the child-serving slots) 15 Before or After Kindergarten (becomes 15 full-time summer care for 12 weeks, but without transportation)

- Evergreen: 56 Pre-School
- Neptune: 72 Pre-School
  5 Infant/Toddler

In accordance with State policy, parents of children receiving State subsidized child care services are assessed a co-payment (fee) based upon their income. This co-payment (fee) is netted out of the relevant maximum per child reimbursement rate paid by the State, as noted in the preceding section. Utilizing the above capacity and program component information, DYFS has calculated the gross total funding allotments (including transportation with the exception of the non-DYFS children at the Bergen Hill Child Care Center not enrolled in the Before or After Kindergarten program and the 5th Street Child Care Center), estimated assessed parental co-payments (fees) and estimated net State allotments in the following chart. Note that the gross total allotment minus the assessed co-payments (fees) from parents and the prepaid base rental costs is the amount of funding that will be provided by DYFS.

The total adjustments to gross contract reimbursements to reflect prepaid base rental charges and assessed parental co-payments (fees), in the initial contracts, are listed below. These prepaid base rental costs may increase in subsequent years due to scheduled increases in the base rent (step-ups), which have been negotiated and included in the existing leases. Any such increases in prepaid base rent will be adjusted from the provider's contract reimbursement. Details regarding any scheduled increases over the terms of these leases are described in the RFP.

Center	Gross Total Allotment	Total Annual Base Rental Costs to be Prepaid by DYFS and Adjusted from Gross Allotment	Estimated Assessed Parental Fees and Adjusted from Gross Allotment	Estimated Net State Allotment: Contract Amount
5th Street	$ 290,326	$ 24,266	$ 40,000	$ 226,060
Trenton	$ 360,214	$ 92,074	$ 7,000	$ 261,140
Bergen Hill	$1,541,366	$460,460**	$120,000	$ 960,906
Evergreen	$ 360,214	N/A	$ 6,000	$ 354,214
Neptune	$ 500,807	$141,485	$ 15,000	$ 344,322
TOTAL	$3,052,927	$718,285	$188,000	$2,146,642

*This amount represents the cost for the four months that will remain on the current lease. After the expiration of the lease the selected provider will have the option of either negotiating and executing a lease for the space currently occupied by this center, or relocate to a new site, provided that the new location is in or in close proximity to the catchment area served by this center—downtown Jersey City—and meets all applicable building, fire, construction and licensing requirements.

The actual base rental cost at Bergen Hill is approximately $60 per child per week (or $788,400 per year). The **balance of the base rental cost—approximately $25 per child per week (or $327,940 per year)—at this center will also be prepaid by the Division but will **not** be adjusted from gross contract reimbursement for this center. The long-term adjustment from the provider's contract reimbursement for the base rent prepaid by DYFS is noted in the RFP.

The actual funding allotments will vary depending on the outcome of final contract negotiations and the actual identification of assessed fees throughout the contract period.

Organizations eligible to apply for funding: In all cases, only the following agencies and organizations are considered eligible to submit a proposal in response to this announcement:

- Social Service Block Grant (SSBG)-funded community-based agencies or child care centers, who operate licensed child care centers within the State, as defined in N.J.A.C. 10:122, Manual of Requirements for Child Care Centers, (N.J.S.A. 30:5B-1 through 15);
- Federally funded Head Start grantee agencies, which operate licensed child care centers within the State, as defined in N.J.A.C. 10:122, Manual of Requirements for Child Care Center, (N.J.S.A. 30:5B-1 through 15);
- Any public or private agency, whether for-profit or not-for-profit, including bonafide church-sponsored programs/organizations, which operate licensed child care centers within the State, as defined in N.J.A.C. 10:122, Manual of Requirements for Child Care Centers, (N.J.S.A. 30:5B-1 through 15); and
- Any public or private agency, whether for-profit or not-for-profit, including bonafide church-sponsored programs/organizations, which **do not** operate licensed child care centers within the State, as defined in N.J.A.C. 10:122, Manual of Requirements for Child Care Centers, (N.J.S.A. 30:5B-1 through 15), but that believe they can meet the requirements of this RFP.

Qualifications needed by an Applicant: In all cases, applicants must meet the following requirements.

1. The applicant must be willing to enter into a contract with DYFS and comply with the contracting rules, regulations and program standards of Department of Human Services;
2. The applicant must give the DYFS employees who are impacted by privatization the "right of first refusal" for employment at the privatized centers in which they currently work. In other words, DYFS employees at these five centers must be offered employment by the selected provider, and given the opportunity to accept or reject this offer, before any non-DYFS persons are tendered an offer of employment for positions at these centers. As part of this requirement, the Division expects that DYFS employees, currently occupying full-time positions at these five centers, will be offered full-time positions by the private provider.
3. The applicant must be willing to adhere to the conditions for funding, program requirements, level of service requirements and restrictions on who may be served as specified in the Request for Proposals (RFP); and
4. The applicant must not discriminate in providing services to clients based on age, race, creed, national origin, sex, handicap or financial status.

Application Selection Criteria: Proposals shall be ranked and rated in accordance with the criteria listed below. The maximum score for all criteria is 100 points.

I. Narrative Sections (Maximum Score: 45)
- Program Description (Maximum Points: 35)—A brief description of the applicant's current effort in providing child care and/or social services.
- Program Model (Maximum Points: 5)—An overview of the proposed program model to include number of classrooms, group size by class and staff to child ratios by classroom.
- Expansion Plan (Maximum Points: 5)—A description of the plan, if applicable, to expand beyond the current operational capacity, without additional state funds. This plan description should include the child care option to be expanded or developed (i.e. pre-school, infant, school-age).

II. Program Activity Plans (Maximum Score: 50)
- Child Care Curriculum (Maximum Points: 20)—A description of the program of activities or curriculum components to be provided, noting any special emphasis in addressing the needs of protective services for children and and their families. This section will also address how parents will be afforded opportunities to be involved and participate in the experiences of their children through a variety of roles and opportunities, as well as the provision of nutritional and, where applicable, transportation services.

  This section should also describe how your agency plans to address/currently addresses the needs of bilingual/bicultural clients who are eligible to receive services from

your agency and who would be eligible to receive services from the child care center(s) which you seek to operate under a contract with DYFS.

- Support Services (Maximum Points: 20)—A listing of the support services, by service component—that is, medical, dental, social services, mental health, etc.—to be provided. This listing should indicate if the support services will be provided directly by the applicant or through linkages with community service providers. This section should also address communications (that is, case conferencing, etc.) with the respective Division offices in the provider's catchment area.
- Staff Development and Training (Maximum Points: 10)—An overview of the staff training plan is to be provided. This plan will include a listing of proposed in-service training sessions and their frequency, as well as the availability of release time and funding for specialized training opportunities and/or workshops.

This section should also document the agency's policies concerning/pertaining to: (1) any certifications to be held by classroom teaching staff, such as DYFS Bureau of Licensing Group Teacher Approval; (2) specialized support staff, i.e. social worker, nurse, speech therapist, to be employed by the applicant; and (3) the average years of experience for classroom teachers and, if applicable, by specialized support staff.

In addition, this section will document the personnel management process for the transition of DYFS employees, including a compensation package that specifies salary ranges and benefits.

III. Budget (Maximum Score: 5)

- Budget Information Summary (Maximum Points: 5)—The completion of the Request for Proposal (RFP): Budget Information Summary—P1.04, Attachment 4—**will be required from any applicant(s) who are not currently under contract to the Division to provide child care services.** This summary must provide contract summary information, RFP budget expense summary information, RFP personnel detail and budget category detail—reflecting a reasonable and appropriate allocation of resources to deliver the required services and maintain a viable program. Applicants currently under contract to DYFS to provide child care services will automatically be scored with five points.

Points will be deducted if any of the required documentation, as specified in the RFP, is not included and/or appended to the proposal.

Procedures for eligible applicants to apply: Agencies and organizations interested in applying for these funds may obtain a copy of the Requests for Proposals by contacting Ron Bruschini, Assistant Administrator, DYFS Office of Statewide Operations and Support, at (609) 292-9515.

DYFS will provide eligible applicants additional and/or clarifying information about the privatization program and application procedures at a **special meeting** indicated below. It is a **prerequisite** and a **requirement** that prospective applicants attend the Bidders' Conference. Failure to attend the Bidders' Conference will disqualify individuals, agencies or organizations from the application process. Those who will attend this conference must confirm their attendance by calling the below listed contact number at least five working days prior to the scheduled date of the meeting:

Date: Wednesday, January 11, 1995
Time: 10:00 A.M.
Place: Department of Personnel—Human Resource Development Institute
Address: 600 College Road East, Building 600—Room 79 (Theater) Plainsboro, NJ
Contact: Ron Bruschini, DYFS Office of Statewide Operations and Support
(609) 292-9515

Inclement weather will not result in the cancellation of the mandatory bidder's conference unless it is of a severity sufficient to cause the official closing or delayed opening of State offices on the above date. In the event of the closure or delayed opening of State offices, the Bidder's Conference will be **canceled** and then held on the following alternate date:

Date: Friday, January 13, 1995
Time: 10:00 A.M.
Place: Department of Personnel—Human Resource Development Institute
Address: 600 College Road East, Building 600—Room 79 (Theater) Plainsboro, NJ

NOTE: Announcements concerning the closure or delayed opening of State Offices are broadcast on radio stations throughout the State.

DYFS—at the telephone number noted above—should be notified if any person with a physical disability, planning to attend this meeting, will require any special accommodations.

Submission of Proposals: Agencies and organizations interested in applying for these funds must submit **one** signed original and **eight** copies of the application, including all attachments comprising the project proposal package, by no later than **5:00 P.M., on February 17, 1995.** Applications may be mailed or hand delivered to the:

Mail Delivery
Division of Youth and Family Services
Office of Statewide Operations and Support
CN 717
Trenton, NJ 08625-0717
Attention: Ron Bruschini

Hand Delivery
Division of Youth and Family Services
Office of Statewide Operations and Support
Capital Center
7th Floor
50 East State Street
Trenton, NJ 08625-0717
Attention: Ron Bruschini

In addition, consistent with the date and time frame indicated above, **one** copy must be sent to the Chairperson and **one** copy to the Staff Person of the appropriate County Human Services Advisory Council. As part of the proposal review process, the County Human Services Advisory Councils will be given the opportunity to provide the Department/Division with comments and recommendations on all proposals submitted for funding in their county.

Date by which applicants shall be notified of acceptance: March 20, 1995.

INSURANCE

(a)

DIVISION OF LEGISLATIVE AND REGULATORY AFFAIRS

Notice of Receipt of and Action on Petition for Rulemaking
Exclusion of "Ophthalmology" from or Substitution of "Licensed Eye Care Practitioner" as Specialist Doctor Benefit in HMO Plan Covered Services at N.J.A.C. 11:20-1.1

Petitioner: New Jersey Optometric Association.

Take notice that on October 14, 1994, the New Jersey Optometric Association ("petitioner") filed a petition with the Department of Insurance ("Department") requesting an amendment to N.J.A.C. 11:20-1.1 to either exclude "ophthalmology" or substitute the term "licensed eye care practitioner."

Specifically, petitioner is requesting an amendment to Exhibit F at N.J.A.C. 11:20, the New Jersey Individual Health Coverage Program ("Program") rules adopted by the Program's Board of Directors ("Board") establishing standard individual health benefits plans and policy forms pursuant to N.J.S.A. 17B:27A-2 et seq., and specifically setting forth the benefits, limitations and exclusions of each plan. Exhibit F in the Appendix to N.J.A.C. 11:20 sets forth the Health Maintenance Organization ("HMO") Benefits Plan. Petitioner seeks to amend Exhibit F at Section V(b) to either exclude the term "ophthalmology" or substitute the term "licensed eye care practitioner."

In accordance with N.J.A.C. 11:1-15.2(a)4, the Department's rule applicable to petitions for rulemaking pursuant to N.J.S.A. 52:14B-4(f), a petitioner seeking to petition the Department to promulgate, amend or repeal a rule is required to submit to the Commissioner inter alia,

references to the authority of the Department to take the requested action. Petitioner in its petition for rulemaking identifies both the Department and the Board as respondents, and states that "the respondent is the administrative agency charged by law with regulation of the practice of insurance and charged with the proposal and adoption of rules regarding the New Jersey Individual Health Coverage Program pursuant to the authority of N.J.S.A. 17B:27A-2 et seq." N.J.S.A. 17B:27A-7 specifically authorizes the Board, rather than the Department, to "... establish the policy and contract forms and benefit levels to be made available by all carriers for the policies required to be issued ..." under the plans established by the Board. The rules and exhibits at N.J.A.C. 11:20 were proposed and adopted by the Board under signature of the Board's Chair, and were neither proposed nor adopted by the Department.

In accordance with N.J.A.C. 1:30-3.6 and 11:1-15, and after thorough review of the petition, the Department is denying petitioner's request. N.J.A.C. 11:20 and Exhibit F of the Appendix thereto were adopted by the Board under its specific authority granted by N.J.S.A. 17B:27A-7. Therefore, the Department has determined that jurisdiction for action on the petition properly rests with the Board.

(a)

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Notice of Receipt of and Action on Petition for Rulemaking

N.J.A.C. 11:21 Appendix Exhibit G

Petitioner: New Jersey Optometric Association.

Take notice that the New Jersey Small Employer Health Benefits Program ("SEH") Board received a petition for rulemaking on October 19, 1994 concerning N.J.A.C. 11:21 Appendix Exhibit G, the small employer health benefits HMO policy form, Section V(b) under "Specialist Doctor Benefits."

The petitioner requests that the SEH Board amend the list of "Specialist Doctor Benefits" by excluding "ophthalmology" from that list or by substituting the term "licensed eye care practitioner."

Notice of Action on Petition for Rulemaking

The petition has been considered by the SEH Board, pursuant to law, and the SEH Board has decided to refer the matter to the SEH Board's Policy Forms Committee for further deliberations in accordance with N.J.A.C. 11:21-18.3(c), and the Policy Forms Committee is to report to the Board and the Board intends to take action at its March 15, 1995 meeting.

The SEH Board's goal is to make the HMO policy form as clear as possible. Therefore, the Board's Policy Forms Committee will further consider the petition, taking into account the list of examples of Specialist Doctor Benefits, and whether a clarification is necessary. When the Policy Forms Committee's recommendation has been considered by the SEH Board and a final decision has been made, the decision will be mailed to the petitioner and published in a future New Jersey Register.

A copy of this notice has been mailed to the petitioner, as required by N.J.A.C. 11:21-18.3(b).

(b)

NEW JERSEY INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Notice of Receipt of and Action on Petition for Rulemaking N.J.A.C. 11:20 Appendix Exhibits A through F

Petitioner: New Jersey Acupuncture Association.

Take notice that the New Jersey Individual Health Coverage Program ("IHC") Board received a petition for rulemaking on November 3, 1994 concerning N.J.A.C. 11:20 Appendix Exhibits A through F, the individual health benefits policy forms.

Specifically, the Petitioner requests that the IHC Board amend the standard policy forms to include acupuncture therapy to the list of covered services.

Notice of Action on Petition for Rulemaking

The petition has been considered by the IHC Board, pursuant to law, and the IHC Board has decided to refer the matter to the IHC Board's Legal Committee for further deliberations and the Legal Committee is to report to the Board. The Board intends to take action on the petition within 90 days.

In developing and amending the standard health benefits plans, the IHC Board's goal is to strike a balance between coverage and affordability. Therefore, the Board's Legal Committee will further consider the petition, taking into account the services already covered in the standard health benefits plans, and the likely cost and desirability of the proposed additional coverage. When the Legal Committee's recommendation has been considered by the IHC Board and a final decision has been made, the decision will be mailed to the Petitioner and published in a future New Jersey Register.

A copy of this notice has been mailed to the Petitioner.

(c)

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Notice of Receipt of and Action on Petition for Rulemaking N.J.A.C. 11:21 Appendix Exhibits A through G

Petitioner: New Jersey Acupuncture Association.

Take notice that the New Jersey Small Employer Health Benefits Program ("SEH") Board received a petition for rulemaking on November 3, 1994 concerning N.J.A.C. 11:21 Appendix Exhibits A through G, the small employer health benefits policy forms.

Specifically, the Petitioner requests that the SEH Board amend the standard policy forms to include acupuncture therapy to the list of covered services.

Notice of Action on Petition for Rulemaking

The petition has been considered by the SEH Board, pursuant to law, and the SEH Board has decided to refer the matter to the SEH Board's Policy Forms Committee for further deliberations in accordance with N.J.A.C. 11:21-18.3(c), and the Policy Forms Committee is to report to the Board. The Board intends to take action on the petition at its March 15, 1995 meeting.

In developing and amending the standard health benefits plans, the SEH Board's goal is to strike a balance between coverage and affordability. Therefore, the Board's Policy Forms Committee will further consider the petition, taking into account the services already covered in the standard health benefits plans, and the likely cost and desirability of the proposed additional coverage. When the Policy Forms Committee's recommendation has been considered by the SEH Board and a final decision has been made, the decision will be mailed to the Petitioner and published in a future New Jersey Register.

A copy of this notice has been mailed to the Petitioner, as required by N.J.A.C. 11:21-18.3(b).

PUBLIC UTILITIES

(d)

BOARD OF PUBLIC UTILITIES

Recovery of Capacity Costs

Notice of Generic Proceeding Regarding the Recovery of Capacity Costs Associated with Electric Utility Power Purchases from Cogenerators and Small Power Producers

Take notice that, by Order issued September 16, 1994, in Docket Number EX93060255, the New Jersey Board of Public Utilities initiated a generic proceeding to consider the recovery of capacity costs associated with electric utility power purchases from cogenerators and small power producers. The appropriate recovery of such costs, specifically the concern that there may be a "double-recovery" of costs resulting from levelized energy adjustment clause treatment of payments to

cogenerators and small power producers, has been an issue before the Board in the context of various litigated proceedings in recent years.

By letter dated April 9, 1994, the Board advised the State's four electric utilities and the Division of Rate Counsel, now the Division of the Ratepayer Advocate, that it would inititate a generic proceeding to explore this issue and solicited the parties' views on the scope of the issues to be addressed when the matter was transmitted to the Office of Administrative Law (OAL) for hearing. The September 16, 1994 Order formalizes the convening of said proceeding and sets forth the scope of the proceeding.

In addition, in order to give both broad and informative notice of this proceeding to as many interested parties as possible, the Board directed that its Order be transmitted to OAL for publication in the New Jersey Register as a Public Notice.

The text of the Board's Order of September 16, 1994, follows:

AGENDA DATE: 2/18/94

State of New Jersey
BOARD OF PUBLIC UTILITIES
Two Gateway Center
Newark, N.J. 07102

IN THE MATTER OF THE BOARD OF PUBLIC UTILITIES' GENERIC PROCEEDING REGARDING RECOVERY OF CAPACITY COSTS ASSOCIATED WITH ELECTRIC UTILITY POWER PURCHASES FROM COGENERATORS AND SMALL POWER PRODUCERS

ELECTRIC
ORDER INITIATING GENERIC PROCEEDING AND RESOLVING MOTIONS
DOCKET NO. EX93060255

BY THE BOARD:

The appropriate recovery of capacity costs associated with electric utility purchases from qualifying facilities ("QFs"), specifically the concern that there may be a "double-recovery" of costs resulting from levelized energy adjustment clause (LEAC) treatment of QF payments, has been an issue before the cost Board of Regulatory Commissioners (Board)[1] in the context of various litigated proceedings in recent years, most particularly in regards to two Jersey Central Power & Light Company (JCP&L) rate proceedings. The Board's consideration of this issue in one of these proceedings, JCP&L's base rate case in Docket No. ER891109125J, resulted in a Board Order dated April 9, 1992, wherein the Board determined that it would be appropriate to convene a generic proceeding to fully address the issue. By Secretary's letter dated July 30, 1993, the Board advised the State's four electric utilities as well as Rate Counsel that it would initiate a generic proceeding to explore this issue and solicited the parties' views on the scope of the issues to be transmitted to the Office of Administrative Law. This Order formalizes the convening of said proceeding, sets forth the scope of the proceeding and resolves several motions which have been filed.

Background:

On December 2, 1988, JCP&L filed a petition with the Board in Docket No. ER8812-1277 requesting approval of an increase in Levelized Energy Adjustment Clause (LEAC). In addition to the traditional true-up of fuel expenses, JCP&L sought to recover through the LEAC charge, the energy and capacity costs associated with its power purchases from qualifying cogenerators and small power producers (QFs) that qualify under the Public Utility Regulatory Policies Act (PURPA). In that proceeding, Rate Counsel[2] opposed the dollar for dollar pass-through of the QF capacity costs on the grounds that to allow JCP&L to fully recover through its LEAC the capacity costs associated with QF power purchases, may result in the utility recovering in rates an amount in excess of the actual capacity costs of these purchases. Rate Counsel claimed that the capacity cost overrecovery would occur as a product of a normalized level of capacity costs being already built into base rates, and the realization of base sales in excess of the sales level assumed in the last base rate case test year. Because these capacity costs would already be recovered in the base rates received by the utility, Rate Counsel argued, allowing an additional unrestricted LEAC recovery as well of all QF capacity costs would amount to a double recovery of capacity costs. Based on this argument, Rate Counsel calculated an overrecovery of $44 million in that LEAC petition and recommended the offset of that amount from the increase in the LEAC requested by JCP&L.

As part of the settlement reached in that proceeding, the parties agreed to reserve their rights to litigate in a Phase II proceeding the merits of Rate Counsel's arguments and the issue of the optimal mechanism for recovery of non-fuel costs associated with power purchase contracts entered into by JCP&L with cogenerators and small power producers that qualify under the Public Utility Regulatory Policies Act regulations as Qualifying Facilities. In the Initial Decision in the Phase II proceeding, Rate Counsel's position was rejected by Administrative Law Judge Sukovich, on the grounds that Board policy allowed the recovery through a utility's LEAC of all production costs related to QFs.

By Order dated November 9, 1989, the Board adopted the ALJ's decision denying Rate Counsel's proposal to offset recovery of $44 million from JCP&L's LEAC. The basis for that decision was the Board's stated commitment to allow utilities a full and timely recovery of QF costs and thus create a "full opportunity for QF development". The Board, however, found that the ALJ's decision inappropriately rested on a misunderstanding of Board policy, because she erroneously extended the policy for LEAC treatment of QF contract costs afforded New Jersey electric utilities via the July 1988 Stipulation of Settlement (SOS), to pre-SOS QF contacts, such as those under consideration in that case. That the Board had not mandated a specific LEAC pass-through of the costs associated with the pre-SOS JCP&L QF contracts was evidence in the Board's April 1989 Order of Clarification approving the power purchase agreement between Public Service Electric & Gas Company (PSE&G) and the Eagle Point Cogeneration Partnership. In that case, the Board approved PSE&G's request for full LEAC recovery of the associated capacity costs, but expressed a desire for and a commitment to the use of an "alternative recovery method" that would both address the "rate design aspects of capacity costs" as well as comply with the Board's policy of full and timely recovery of QF power purchase costs (BPU Docket No. EM88020331, April 14, 1989).

In this climate of a search for the optimal QF capacity cost recovery mechanism, the Board, while adopting the ALJ's denial of Rate Counsel's $44 million proposed adjustment in the Phase II proceeding, declared itself ready to "continue to monitor the financial impact on the utilities due to allowing full QF cost recovery in the LEAC with consideration of remedies if the situation so warrants." (BRC Docket No. ER8812-1277, November 9, 1989)

As noted above, the Board, in its JCP&L LEAC Order of November 9, 1989, expressed its concern regarding the appropriateness of collecting non-fuel costs in the LEAC. The Board Order also expressed the concern that, in general, the dollar for dollar LEAC pass-through of QF capacity costs could potentially have the perverse effect of not only blunting the impetus for efficiency provided by base rates and thus transfering risk onto the ratepayers, but could also shield utility non-fuel costs and the resultant rate adjustments from the scrutiny of the utility's revenues, expenses, capital and rate of return associated with a base rate case.

The issue of recovery of QF capacity costs in the LEAC was next addressed in JCP&L's base rate case, Docket No. ER891109125J, in the context of a proposed new Capacity Adjustment Clause (CAC). This CAC was proposed by JCP&L to recover on a demand basis, rather than on an energy basis, capacity costs associated with purchases from QFs. Rate Counsel countered with a proposal for an automatic adjustment that would account for "overcollections" of capacity costs via a capacity adjustment clause similar to the LEAC. This mechanism, Rate Counsel argued, would avoid the potential of overrecovery of capacity costs that would occur if sales exceed the test year forecast.

The Board was not convinced at that time of the necessity of creating a separate CAC rider as proposed by JCP&L and modified by Rate Counsel. By Order dated April 9, 1992 the Board rejected those proposals but reiterated its readiness to reapproach this issue "should the nature of future purchases or refinements to the cost allocation approach warrant". The Board accepted the position of Staff in that case and found that, in order to identify any "double recovery", the QF costs cannot be looked at in isolation, as proposed by Rate Counsel, but must be examined in the context of the totality of the utility's current costs and revenues. Further, the Board determined that it would be appropriate to convene a generic hearing encompassing all New Jersey electric utilities to consider the base cost offset provisions of the capacity cost recovery mechanism proposed by Rate Counsel, since QF capacity cost recovery is an issue which affects all electric utilities.

Electric utilities purchase power not only from QFs but also from non-utility generators (NUGs) and engage in substantial long and short term

inter-utility power purchase transactions. Payments for these purchases frequently include charges for capacity and energy. Presently, the recovery of the capacity costs related to inter-utility purchases are restricted to treatment in base rates while the energy costs are subject to true-up in the LEAC. Indeed, this differential cost recovery treatment was raised as an issue in the July 1993 Advisory Council report prepared under Commissioner Armenti's direction.

Procedural History of the Generic Proceeding:

In light of the foregoing, at its July 7, 1993 agenda meeting, the Board voted to initiate a generic proceeding to address the appropriate recovery of the capacity costs associated with electric utility power purchases from non-utility generation (NUG) projects, specifically as it relates to a potential "double recovery" of NUG costs by utilities produced by the existing rate recovery policy. The Board indicated that it would examine the issue of purchased power capacity cost recovery in a broader context, including purchases from other utilities, with a view toward determining an economically sound cost recovery mechanism that is fair to New Jersey electric utilities and their customers. The Board indicated its intent to set forth in a prehearing order the scope of issues essential to determining the appropriate methodology for the recovery of purchased power capacity costs.

The Board determined to bifurcate the proceeding into two phases. The first phase will consist of a fact finding hearing to be held at the Office of Administrative Law (OAL) to determine the potential, if any, for double recovery of capacity costs as Rate Counsel has alleged. The second phase will allow the Board to render a decision on both the validity of Rate Counsel's claim of double recovery caused by the LEAC pass-through of NUG capacity charges based on the findings from the first phase at the OAL, as well as the broader policy issues relating to the appropriate purchased power capacity cost recovery mechanism.

By Secretary's letter dated July 20, 1993, the Board invited the four New Jersey electric utilities and Rate Counsel to contribute their views to the scoping of the issues pertinent to the first phase of this proceeding at a pretransmittal conference held on August 3, 1993. At the August 3, 1993 pre-transmittal conference, Board Staff presented a proposed outline of the scope of the issues to be contained in the Board's pending transmittal letter to the OAL. This outline listed the following items: (1) the determination of the existence or lack of double recovery as a result of the traditional LEAC pass-through of NUG capacity costs; (2) the quantification of any such double recovery found to exist; (3) a determination of an appropriate remedy or adjustment if and when such double recovery is found to occur; and (4) the period(s) of time over which such an adjustment would be applicable.

Discussions between the parties at the conference centered on whether or not to apply any adjustment for double recovery retroactively, or whether to only apply such adjustments prospectively if and when double recovery is determined to occur. Rate Counsel contended that it had reserved its right in certain prior LEAC proceedings to seek rate refunds of such excess recovery if and when found by the Board to exist. The parties agreed that Rate Counsel would provide a list of the LEAC cases for which it claimed that it had reserved the right to seek recovery of "overcollections" and that the other parties would have the opportunity to respond.

By letter dated August 17, 1993, Rate Counsel provided a list of prior and current LEAC proceedings for which it planned to seek adjustments for double recovery of capacity costs. Rate Counsel's letter indicated that it would seek adjustments for the following dockets if double recovery is found to have taken place:

a) Jersey Central Power and Light—"Beginning with the LEAC period covered in Docket No. ER89110912J dated April 9, 1992 and through subsequent LEAC periods, including those covered in Docket No. ER91121765J dated April 15, 1992 as well as the current LEAC, BRC Docket No. ER93010009."
b) Atlantic City Electric Company (ACE)—BRC Docket No. ER9202053J and BRC Docket No. ER93030107.
c) Public Service Electric and Gas—BRC Docket No. ER92100989.
d) Rockland Electric Company (RECO)—BRC Docket No. ER93090347.

Utility Motions For Summary Judgment

The four electric utilities responded to Rate Counsel's letter of August 17, 1993. JCP&L, PSE&G, and ACE responded by filing motions for summary judgment on the issue of adjustments to concluded and pending LEAC cases. The utilities urged the Board to summarily deny Rate Counsel's request for an adjustment to past and current LEACs even if the utilities are determined to have overrecovered NUG capacity costs in the past. RECO argued that the double recovery issue should be litigated in the generic proceeding, not in its LEAC proceeding.

The utilities asserted the position that the Board Order approving the Stipulation of Settlement in Docket No. 8010-687B assured the utilities full and timely recovery from ratepayers, through the LEAC or its successor clause, of all costs associated with Board approved NUG contracts over the full terms of the power purchase agreements. They argued that any tinkering with this recovery mechanism might lead to contract disputes between the utilities and the developers of these existing projects and their lenders, given that the assurance of full and timely recovery of these costs provided a vital impetus to the consummation of these contracts. The utilities further argued that any retroactive adjustments to rates associated with these contracts would be contrary to law and would violate the New Jersey Supreme Court's ruling against retroactive ratemaking. The rates approved by the Board in previous LEAC's, they contended, are deemed final and must be relied upon by the utilities, their investors and ratepayers alike and therefore cannot be retroactively modified.

The utilities further contended that a generic proceeding of this nature involves matters of broad regulatory policy and allows for the gathering and scrutiny of facts to enable the development of rules and policies for prospective application. Accordingly, the utilities contended, this proceeding is not a proper forum for arguing the merits of individual rate cases. They asserted that Rate Counsel could have fully litigated its claims of double recovery in any and all of the individual affected past LEAC cases while they are pending, but declined to pursue that option.

Rate Counsel Response

By letter dated October 15, 1993, Rate Counsel responded to the utilities' motions for summary judgment. Rate Counsel asserted that the concept of retroactive ratemaking did not apply to unconcluded LEAC dockets, since the question of double recovery was an issue in those cases which had not yet been adjudicated. Rate Counsel argued that any decision rendered by the Board on the question of double recovery could be fully and properly applicable to these LEAC cases. Rate Counsel identified the unconcluded open LEAC dockets in question as: (1) JCP&L Docket No. ER93010009; (2) PSE&G Docket No. ER92100989J; and (3) RECO Docket No. ER93090347.

Rate Counsel also asserts that in several past adjudicated LEAC rate proceedings, it had properly reserved its right to revisit and litigate the issue of double recovery and, if and when its position prevailed, to seek appropriate rate adjustments to offset such past overrecovery. Rate Counsel claimed that it had merely delayed, but not abandoned, its quest for the proper adjustments of rates in those dockets. It did not fully litigate the issue of double recovery in those cases because of the desire to avoid the potential multiple hearings of this issue. It was felt that a generic proceeding would provide a more efficient forum for tackling this issue. Some of the past LEAC cases in question were resolved by stipulation and Rate Counsel contended that it had properly reserved the right to revisit both prospective and actual revenues with respect to this issue under those stipulations. Rate Counsel argued that a denial of its request for adjustments to past LEACs would constitute a modification of those stipulated agreements, which by the nature and terms of such stipulations would render them void and require the associated dockets to be reopened. Further, Rate Counsel argued that the material facts here in dispute deserve to be heard in a generic proceeding and that, ratepayers' rights of due process would be violated unless the utilities' motions for summary judgment were denied.

Board Staff Comments:

Board Staff addressed the issues raised by the utilities and Rate Counsel in a brief dated November 15, 1993. Staff noted that the double recovery issue was addressed by the Board in prior JCP&L LEAC proceedings (BRC Docket Nos. ER88121277 and ER89110912J). Staff stressed that while the Board did not rule out the potential for double recovery occurring in the LEAC due to the pass-through of all NUG costs, it rejected the specific adjustments sought by Rate Counsel in those cases on the grounds that the impact of double recovery, if any, could only be determined by evaluating the overall earnings of the company. Based on this, Staff opposes any adjustment to the LEAC rates set in JCP&L Docket No. ER89110912J and any retroactive adjustments of rates set by the Board in previously adjudicated cases where the right to pursue the issue of double recovery was not specifically reserved.

With respect to the two ACE LEACs in question, Staff expressed its conviction that the parties in these cases specifically acknowledged in the stipulations settling those cases, the double recovery issue and Rate Counsel's right to seek appropriate adjustment if necessary. ACE in signing the stipulations acknowledged, by the terms of those stipulations, Rate Counsel's right to argue for such an adjustment in this generic proceeding. However, while Staff felt that the Board would not violate the prohibition against retroactive ratemaking by adjusting the rates in those two LEAC dockets, Staff counseled against such action by the Board. Staff contended that it would be bad policy for the Board to retroactively modify its longstanding policy of allowing the full flow through of NUG purchase costs in the LEAC.

Regarding the open LEAC Dockets, namely PSE&G LEAC Docket No. ER921000989J, JCP&L LEAC Docket No. ER9301009 and RECO LEAC Docket No. ER93090347, Board Staff supports Rate Counsel's position that these cases remain fully subject to the outcome of the generic proceeding. Consequently, Staff would not consider any adjustments to the rates determined in these cases as a result of the outcome of the generic hearing to be retroactive.

Should the generic proceeding so prescribe, Staff believes that adjustments for overrecoveries can and should be applied to cost recoveries associated with existing NUG purchases, if and when overrecovery of costs occur. Staff does not support, as a policy matter, a retroactive LEAC adjustment of costs associated with existing NUG contracts, since such adjustments could have serious deleterious impacts on the utilities. Nonetheless, Staff argues that, in approving these contracts, the Board did not immunize the utilities' rates from prospective adjustments intended to correct for cost recoveries above Board-approved levels, should such overrecoveries occur.

Discussion

As a threshold issue, it is critical to reemphasize the dual aspects of this proceeding, as set forth in the Board Secretary's letter of July 20, 1993, soliciting the input of the utilities and Rate Counsel with respect to the scoping of this matter. The Board stated that in this generic proceeding it wished not only to determine the validity of Rate Counsel's claim of double recovery in NUG capacity cost recovery, but also to re-examine the issue of purchased power capacity cost recovery in general, with a view toward synthesizing an economically sound and equitable cost recovery scheme. While the planned proceeding at the OAL will be restricted to the issue of double recovery, it is the Board's intent that the broader policy issue of capacity cost recovery will be reviewed separately by the Board with appropriate consideration given to the results of the fact finding proceedings at the OAL. Therefore, to the extent that the utilities have argued in their motions for summary judgment that the Board should not issue a definitive decision on either the double recovery issue or the proper, prospective cost recovery mechanism for power purchases, such arguments are contrary to the very nature of this generic proceeding and are rejected outright by this Board.

Retroactive Recovery of Overrecovery Costs

The Board has allowed utilities to recover all payments (both capacity and energy costs) associated with NUG purchases through the LEAC since 1981. Utilities have been permitted a dollar-for-dollar flow through in rates with no adjustments made to compensate for the alleged double recovery.

As noted above, the double recovery issue was raised by Rate Counsel and addressed by the Board specifically in two prior LEAC proceedings (JCP&L LEACs—Docket Nos. ER88121277 and ER89110912J). In both cases, while not ruling out the potential for possible double recovery, the Board rejected Rate Counsel's specific proposed adjustments. In these cases the Board stated that the impacts of any possible double recovery could only be detected by assessing the earnings or overall cost and revenue structure of the utility.

Based on our review of the background of this matter and the submission of the parties, the Board rejects and denies Rate Counsel's request to obtain retroactive adjustments to rates established by the Board as the result of past litigated LEAC cases where there was no specific reservation of the right to pursue the double recovery issue. Rate Counsel, in support of its quest for retroactive adjustment of JCP&L's LEAC rates, asserted that the Board, in rejecting Rate Counsel's request for adjustment to an alleged over-recovery in JCP&L LEAC Docket No. ER89110912J, "contemplated that LEAC rates could be adjusted based on the results" of this generic proceeding. A careful reading of that Order gives no indication whatsoever that the Board contemplated such a retroactive adjustment of rates. The Board merely ordered "the continued recovery of QF capacity costs via JCP&L's LEAC at the level presently set therein" pending further Board action as a result of a generic hearing. The Board's clearly expressed intent in that Order was to maintain the existing recovery mechanism and to consider a prospective modification of same in the future if so dictated by the outcome of the generic proceeding. The Board rejects Rate Counsel's interpretation of that Order and hereby precludes any adjustments to the LEAC rates established in Docket No. ER89110912J as a result of this proceeding.

The two ACE LEACs at issue factually differ from the JCP&L cases, because the parties specifically acknowledged the double recovery issue and Rate Counsel's right to seek an adjustment of the LEAC rates established therein. In Docket No. ER92099253J, the Board's Order approved a stipulation which contained the following paragraph:

> 8. . . . Inasmuch as agreement cannot be reached on this issue [double recovery of capacity costs], but in light of the fact that all other issue with respect to this LEAC proceeding have been resolved . . . the parties respectively recommend that the terms of the within Stipulation with respect to paragraphs 1 through 7 be implemented by the Board as soon as possible. The parties further agree that Rate Counsel may move before the Board to have the above-described "double recovery" issue considered in this proceeding, instead of in the generic proceeding contemplated in the Board's April 9, 1992 Order in Docket No. ER89110912J. [BRC order in Dkt. No. ER92020253J, October 13, 1992, stipulation at page 5].

The Board Order adopting this stipulation states that:

> . . . Rate Counsel indicated its position that an adjustment should be made to the Company's EA and HCSA rates to reflect Rate Counsel's position regarding the alleged double recovery of capacity costs . . . The parties were unable to reach an agreement on this [double recovery] issue. However, in light of the fact that all other issues with respect to this LEAC proceeding have been resolved among the parties as outlined above . . . the parties recommend that the terms of the EA and HCSA Settlement be implemented by the Board as soon as practicable, and that said implementation not be delayed as a result of litigation of the double recovery issue. [Id. at p. 2].

Moreover, in the subsequent ACE LEAC, Docket No. ER93030107, the parties agreed to a stipulation that contained the following paragraph:

> 10. The parties acknowledge and agree with respect to the issue of "double recovery" of capacity costs alleged by Rate Counsel to occur as a result of NUG capacity charges being recovered through the LEAC, that (i) the Board has initiated a generic proceeding (Docket No. EX93060255) for the purpose of considering this issue; (ii) insofar as Rate Counsel's allegation raises numerous factual and policy issues, the generic proceeding is the proper forum for all parties to raise issues related thereto; and (iii) all parties hereto expressly reserve all rights with respect to their ability to raise and argue any positions in the generic proceeding on this issue to the same extent such issues could have been raised in this LEAC proceeding and the fact of the settlement of the LEAC proceeding shall in no way prejudice any parties' right in the generic proceeding. [BRC order in Dkt. No. ER93030107, Sept. 29, 1993, stipulation at [10].

It is clear that Rate Counsel reserved its right to argue for an adjustment to the LEAC rates set in both above-referenced ACE LEAC cases. Moreover, by signing these stipulations, ACE acknowledged that Rate Counsel had the right to argue for such an adjustment in this generic proceeding. The Board adopted the language of the stipulations without modification. Accordingly, the LEAC rates established in Docket Nos. ER92099253J and ER93030107 cannot be considered final until a final determination of the double recovery issue is reached in this generic proceeding. Thus, the Board would not violate the prohibition against retroactive ratemaking by adjusting the rates in these two ACE LEAC dockets. Accordingly, the Board denies ACE's motion for summary judgment as it applies to the Board's ability to order an adjustment to the rates set in Docket Nos. ER92099253J and ER93030107. Similarly, the Board agrees that Rate Counsel has kept open the recently stipulated RECO LEAC in Docket No. ER93090347 for purposes of litigating the double recovery issue.

The Board concurs with Rate Counsel that unless they are resolved without reservation of this issue prior to the conclusion of this proceed-

ing, the proceedings PSE&G LEAC Docket No. ER921000989J and JCP&L LEAC Docket No. ER93010009 and any presently open electric utility LEAC dockets, are fully subject to the outcome of the within hearing. Therefore, the conclusion of this generic hearing can be applied to these matters.

Prospective Rate Adjustments and Existing NUGs

In the event the Board confirms the existence of a double recovery in the LEAC pass-through of NUG capacity costs, the utilities may be subject to prospective rate adjustments to correct for over-recoveries that may ensue from future utility recovery of costs associated with existing utility NUG contracts. Notwithstanding the fact that utilities in the past may have received a financial windfall as a result of NUG payment recovery, we believe that it would be inappropriate to perpetuate such a windfall prospectively over the many years possible remaining on such contracts, by precluding any prospective correction to the utilities' purchased power cost recovery mechanisms. We have allowed a pass-through of all legitimate NUG costs in the LEAC but will not allow a continued overrecovery of these costs if and when determined to exist. The Board has the duty to prospectively remedy inappropriate and inequitable cost recovery mechanisms should this, in fact, prove to be the case in this instance.

The Board is fully cognizant of the existing Board policy which allows a timely recovery through the LEAC of all legitimate and prudently-incurred costs associated with Board-approved utility NUG contracts. This fact will certainly weigh heavily into any Board decision concerning future recovery of capacity costs.

Conclusion

The Board **HEREBY** confirms the establishment of this generic proceeding to review the utility power purchase cost recovery methodology issues as outlined in this Order. With respect to the utilities' motions for summary judgment, the Board **HEREBY:** (1) **GRANTS** JCP&L's motion for summary judgment only to the extent that the LEAC rates set in Docket No. ER89110912J cannot be modified as a result of the instant proceeding; (2) **DENIES** ACE's motion for summary judgment as it pertains to Docket Nos. ER92099253J and ER93031007, because Rate Counsel and ACE specifically agreed that the LEAC rates established therein were subject to possible adjustment as a result of this generic proceeding; (3) **DENIES** all other aspects of JCP&L's, ACE's, and PSE&G's motions for summary judgment; and (4) **FINDS** that it has not immunized the costs associated with existing and new non-utility generated power purchase contracts from appropriate rate adjustments to prospectively remedy cost over-recoveries if and where they are found to occur. The scope of the issues to be resolved in the first phase of this proceeding shall include: (i) the determination of the existence or lack of double recovery as a result of the traditional LEAC pass-through of NUG capacity costs; (ii) the quantification of any such double recovery found to exist for each utility for the relevant periods; (iii) a determination of an appropriate remedy or adjustment if and when such double recovery is found to occur, and the period(s) of time over which such an adjustment would be applicable. Following the conclusion of this first phase of the proceeding, the Board in the second phase will render a final decision regarding the specific OAL findings and address the broader issues relating to the appropriate prospective purchased power cost recovery methods. The Board anticipates entertaining briefs on the policy issues subsequent to the OAL phase of this review.

The Board **HEREBY DIRECTS** Staff to transmit this matter to the OAL for evidentiary hearings consistent with the terms of this Order. The Board also **APPROVES** the publication of this Order in the New Jersey Register to notify interested parties of the Board's commencement of its generic review.

DATED: September 16, 1994

BOARD OF REGULATORY COMMISSIONERS BY:

HERBERT H. TATE JR.
PRESIDENT

CARMEN J. ARMENTI
COMMISSIONER

DR. EDWARD H. SALMON
COMMISSIONER

ATTEST: BLOSSOM A. PERETZ, ESQ.
SECRETARY

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1. By Reorganization Plan No. 001-1994, the Board of Regulatory Commissioners was redesignated the Board of Public Utilities.
2. By L.1993, c.58, the Department of the Public Advocate was abolished as a principal department in the Executive Branch. By Reorganization Plan 001-1994, the Division of Ratepayer Advocate was created within the Board of Public Utilities and certain personnel of the Division of Rate Counsel were transferred to the newly formed Division. References herein to the Division of Rate Counsel are meant to refer to the Division of Ratepayer Advocate in so far as it has assumed the functions and duties of the Division of Rate Counsel's intervention in this matter.

REGISTER INDEX OF RULE PROPOSALS AND ADOPTIONS

The research supplement to the New Jersey Administrative Code

A CUMULATIVE LISTING OF CURRENT PROPOSALS AND ADOPTIONS

The **Register Index of Rule Proposals and Adoptions** is a complete listing of all active rule proposals (with the exception of rule changes proposed in this Register) and all new rules and amendments promulgated since the most recent update to the Administrative Code. Rule proposals in this issue will be entered in the Index of the next issue of the Register. **Adoptions promulgated in this Register have already been noted in the Index by the addition of the Document Number and Adoption Notice N.J.R. Citation next to the appropriate proposal listing.**

Generally, the key to locating a particular rule change is to find, under the appropriate Administrative Code Title, the N.J.A.C. citation of the rule you are researching. If you do not know the exact citation, scan the column of rule descriptions for the subject of your research. To be sure that you have found all of the changes, either proposed or adopted, to a given rule, scan the citations above and below that rule to find any related entries.

At the bottom of the index listing for each Administrative Code Title is the Transmittal number and date of the latest looseleaf update to that Title. Updates are issued monthly and include the previous month's adoptions, which are subsequently deleted from the Index. To be certain that you have a copy of all recent promulgations not yet issued in a Code update, retain each Register beginning with the November 7, 1994 issue.

If you need to retain a copy of all currently proposed rules, you must save the last 12 months of Registers. A proposal may be adopted up to one year after its initial publication in the Register. Failure to adopt a proposed rule on a timely basis requires the proposing agency to resubmit the proposal and to comply with the notice and opportunity-to-be-heard requirements of the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.), as implemented by the Rules for Agency Rulemaking (N.J.A.C. 1:30) of the Office of Administrative Law. If an agency allows a proposed rule to lapse, "Expired" will be inserted to the right of the Proposal Notice N.J.R. Citation in the next Register following expiration. Subsequently, the entire proposal entry will be deleted from the Index. See: N.J.A.C. 1:30-4.2(c).

Terms and abbreviations used in this Index:

N.J.A.C. Citation. The New Jersey Administrative Code numerical designation for each proposed or adopted rule entry.

Proposal Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of a proposed amendment or new rule.

Document Number. The Registry number for each adopted amendment or new rule on file at the Office of Administrative Law, designating the year of promulgation of the rule and its chronological ranking in the Registry. As an example, R.1994 d.1 means the first rule filed for 1994.

Adoption Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of an adopted amendment or new rule.

Transmittal. A series number and supplement date certifying the currency of rules found in each Title of the New Jersey Administrative Code. Rule adoptions published in the Register after the Transmittal date indicated do not yet appear in the loose-leaf volumes of the Code.

N.J.R. Citation Locator. An issue-by-issue listing of first and last pages of the previous 12 months of Registers. Use the locator to find the issue of publication of a rule proposal or adoption.

MOST RECENT UPDATE TO THE ADMINISTRATIVE CODE: SUPPLEMENT OCTOBER 17, 1994

NEXT UPDATE: SUPPLEMENT NOVEMBER 21, 1994

Note: If no changes have occurred in a Title during the previous month, no update will be issued for that Title.

N.J.R. CITATION LOCATOR

If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register	If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register
25 N.J.R. 5729 and 6084	December 20, 1993	26 N.J.R. 2693 and 2828	July 5, 1994
26 N.J.R. 1 and 280	January 3, 1994	26 N.J.R. 2829 and 3102	July 18, 1994
26 N.J.R. 281 and 520	January 18, 1994	26 N.J.R. 3103 and 3230	August 1, 1994
26 N.J.R. 521 and 878	February 7, 1994	26 N.J.R. 3231 and 3504	August 15, 1994
26 N.J.R. 879 and 1178	February 22, 1994	26 N.J.R. 3505 and 3780	September 6, 1994
26 N.J.R. 1179 and 1272	March 7, 1994	26 N.J.R. 3781 and 3916	September 19, 1994
26 N.J.R. 1273 and 1416	March 21, 1994	26 N.J.R. 3917 and 4120	October 3, 1994
26 N.J.R. 1417 and 1554	April 4, 1994	26 N.J.R. 4121 and 4244	October 17, 1994
26 N.J.R. 1555 and 1738	April 18, 1994	26 N.J.R. 4245 and 4470	November 7, 1994
26 N.J.R. 1739 and 1904	May 2, 1994	26 N.J.R. 4471 and 4720	November 21, 1994
26 N.J.R. 1905 and 2166	May 16, 1994	26 N.J.R. 4721 and 4856	December 5, 1994
26 N.J.R. 2167 and 2510	June 6, 1994	26 N.J.R. 4857 and 5138	December 19, 1994
26 N.J.R. 2511 and 2692	June 20, 1994		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
ADMINISTRATIVE LAW—TITLE 1				
1:7A	Department of Environmental Protection cases	26 N.J.R. 4124(a)		
1:14-10	BRC ratemaking hearings: discovery	26 N.J.R. 3(a)		
1:14-10	BRC ratemaking hearings: extension of comment period regarding discovery process	26 N.J.R. 883(a)		
	Most recent update to Title 1: TRANSMITTAL 1994-5 (supplement September 19, 1994)			
AGRICULTURE—TITLE 2				
2:5	Quarantines and embargoes on animals	26 N.J.R. 1908(b)		
2:6	Animal health: biological products for diagnostic or therapeutic purposes	26 N.J.R. 3784(a)		
2:33	Agricultural fairs	26 N.J.R. 285(a)		
2:34	Equine Advisory Board rules	26 N.J.R. 3919(a)		
	Most recent update to Title 2: TRANSMITTAL 1994-6 (supplement September 19, 1994)			
BANKING—TITLE 3				
3:1-4.5	Governmental unit deposit protection: public funds exceeding 75 percent of capital funds	26 N.J.R. 2832(a)	R.1994 d.558	26 N.J.R. 4347(a)
3:1-6.6	Department examination charges	26 N.J.R. 1560(b)		
3:1-16.2, 16.5	Mortgage commitments, lender advertising and licensure, surety bond amounts	26 N.J.R. 3234(a)	R.1994 d.559	26 N.J.R. 4347(b)
3:2-1.4	Mortgage commitments, lender advertising and licensure, surety bond amounts	26 N.J.R. 3234(a)	R.1994 d.559	26 N.J.R. 4347(b)
3:4-3	Banking institutions: sale of alternative investments	25 N.J.R. 5733(a)		
3:18-1.1, 1.3, 3.2, 7.4, 8.1, 8.2, 12	Secondary Mortgage Loan Act rules	26 N.J.R. 3920(a)		
3:22	Insurance premium finance companies	26 N.J.R. 2697(a)	R.1994 d.562	26 N.J.R. 4348(a)
3:33	Acquisitions by out-of-State entities: application requirements	26 N.J.R. 3235(a)	R.1994 d.560	26 N.J.R. 4349(a)
3:38-1.1, 1.10, 5.3	Net worth of mortgage lenders	26 N.J.R. 4124(b)	R.1994 d.629	26 N.J.R. 4999(a)
3:38-5.3	Mortgage referrals by real estate agents	26 N.J.R. 6(a)		
3:38-5.3	Mortgage referrals by real estate agents: extension of comment period	26 N.J.R. 884(a)		
3:40-1.9	New Jersey Cemetery Board: organizational meetings	26 N.J.R. 4475(a)		
3:40-6	New Jersey Cemetery Board: applications	26 N.J.R. 3785(a)	R.1994 d.579	26 N.J.R. 4597(a)
3:41-12	Cemetery Board: service contractors and service contracts	26 N.J.R. 6(b)		
3:41-13.8–3.10	New Jersey Cemetery Board: applications	26 N.J.R. 3785(a)	R.1994 d.579	26 N.J.R. 4597(a)
	Most recent update to Title 3: TRANSMITTAL 1994-6 (supplement August 15, 1994)			
CIVIL SERVICE—TITLE 4				
	Most recent update to Title 4: TRANSMITTAL 1992-1 (supplement September 21, 1992)			
PERSONNEL—TITLE 4A				
4A:1-2.3	Department use of Social Security numbers	26 N.J.R. 287(a)		
4A:2-2.3	Sexual harassment	26 N.J.R. 3507(a)	R.1994 d.618	26 N.J.R. 5000(a)
4A:2-3.1	Department use of Social Security numbers	26 N.J.R. 287(a)		
4A:2-3.1	Performance evaluations	26 N.J.R. 3509(a)		
4A:3-3.1	Department use of Social Security numbers	26 N.J.R. 287(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
4A:3-4.6	Voluntary furlough program	26 N.J.R. 4126(a)		
4A:4-1.10	Personnel action freezes	26 N.J.R. 3510(a)	R.1994 d.619	26 N.J.R. 5002(a)
4A:4-2.1	Department use of Social Security numbers	26 N.J.R. 287(a)		
4A:4-2.15, 5.2	Voluntary furlough program	26 N.J.R. 4126(a)		
4A:6-1.1, 1.3, 1.6, 1.8, 1.10, 1.21, 1.21B, App.	Family and medical leave	26 N.J.R. 3511(a)	R.1994 d.620	26 N.J.R. 5002(b)
4A:6-1.2, 1.3, 1.5, 1.23, 2.4	Voluntary furlough program	26 N.J.R. 4126(a)		
4A:6-4.2	Department use of Social Security numbers	26 N.J.R. 287(a)		
4A:6-5.3	Performance evaluations	26 N.J.R. 3509(a)		
4A:7-1.3, 3.3, 3.4	Sexual harassment	26 N.J.R. 3507(a)	R.1994 d.618	26 N.J.R. 5000(a)
4A:8	Layoffs	26 N.J.R. 3518(a)		
4A:8-2.4	Voluntary furlough program	26 N.J.R. 4126(a)		
4A:8-2.4	Family and medical leave	26 N.J.R. 3511(a)	R.1994 d.620	26 N.J.R. 5002(b)

Most recent update to Title 4A: TRANSMITTAL 1994-6 (supplement October 17, 1994)

COMMUNITY AFFAIRS—TITLE 5

5:12	Homelessness Prevention Program	26 N.J.R. 4248(a)		
5:18	Uniform Fire Code	26 N.J.R. 4258(a)		
5:18-1.5, 2.7, 2.8, 2.22, 3.3, 3.4, 3.5, 4.9, 4.13	Uniform Fire Code requirements	26 N.J.R. 4249(a)		
5:18-2.4A	Uniform Fire Code: overnight camps life hazard use category	26 N.J.R. 4254(a)		
5:18-2.11A	Construction boards of appeal: UCC and Fire Code appeals	26 N.J.R. 4254(b)		
5:18-2.12, 2.21, App. 3-A	Uniform Fire Code: cigarette lighters	26 N.J.R. 2182(b)		
5:18A	Fire Code Enforcement	26 N.J.R. 4258(a)		
5:18B	High Level Alarms	26 N.J.R. 4258(a)		
5:18C	Standards for Fire Service Training and Certification	26 N.J.R. 4258(a)		
5:18C-2.4	Fire service training facilities	26 N.J.R. 4249(a)		
5:23-2.9, 2.34–2.37, 4.40	Construction boards of appeal: UCC and Fire Code appeals	26 N.J.R. 4254(b)		
5:23-3.4, 3.20A	Indoor air quality subcode	25 N.J.R. 5918(a)		
5:23-3.14, 7	Uniform Construction Code: Barrier Free Subcode	26 N.J.R. 2698(a)		
5:23-3.14, 7	Barrier Free Subcode: correction of public hearing date	26 N.J.R. 3524(a)		
5:23-4.3	Uniform Construction Code: administrative changes regarding municipal enforcing agencies	———	———	26 N.J.R. 5007(a)
5:23-8.11	Asbestos safety control monitor: administrative correction	———	———	26 N.J.R. 4760(a)
5:23-10.1, 10.3, 10.4	Radon Hazard Subcode: schools and residential buildings in tier one areas	26 N.J.R. 2704(a)	R.1994 d.609	26 N.J.R. 5007(b)
5:25-2.5	New home warranties and builder registration: denial of registration	26 N.J.R. 1913(a)	R.1994 d.610	26 N.J.R. 5010(a)
5:26-8.2	Planned real estate developments: community association meeting location	26 N.J.R. 4277(a)		
5:31	Local authorities	26 N.J.R. 4128(a)		
5:34-7.6, 7.8, 7.9	Local government finance: renewal of registration of Cooperative Purchasing System	26 N.J.R. 4724(a)		
5:37	Municipal, county and authority employees deferred compensation plans	26 N.J.R. 2708(a)	R.1994 d.578	26 N.J.R. 4600(a)
5:80-5.10	Housing and Mortgage Finance Agency: prepayment of project mortgage	26 N.J.R. 1187(a)		
5:93-3.6, 5.6	New Jersey Council on Affordable Housing: reductions for substantial compliance; zoning for inclusionary development	26 N.J.R. 2514(a)	R.1994 d.563	26 N.J.R. 4349(a)

Most recent update to Title 5: TRANSMITTAL 1994-9 (supplement October 17, 1994)

MILITARY AND VETERANS' AFFAIRS—TITLE 5A

Most recent update to Title 5A: TRANSMITTAL 1994-1 (supplement June 20, 1994)

EDUCATION—TITLE 6

6:7	State-operated school districts	26 N.J.R. 3524(b)	R.1994 d.616	26 N.J.R. 5010(b)

Most recent update to Title 6: TRANSMITTAL 1994-8 (supplement October 17, 1994)

ENVIRONMENTAL PROTECTION—TITLE 7

7:0	Management of waste oil: request for public comment	26 N.J.R. 1466(a)		
7:1C-1.5	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:1G-2.1, 3.1	Community Right to Know: EPA list of regulated substances for accidental release prevention; hazardous substance reporting threshold	26 N.J.R. 2833(a)	R.1994 d.576	26 N.J.R. 4606(a)
7:1H	County Environmental Health Act rules: pre-proposal	26 N.J.R. 3526(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
7:1L	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:4A-2.3	Historic Preservation Bond Program	26 N.J.R. 3253(b)	R.1994 d.541	26 N.J.R. 4350(a)
7:4B-3.1	Historic Preservation Bond Program	26 N.J.R. 3253(b)	R.1994 d.541	26 N.J.R. 4350(a)
7:4C	Historic Preservation Bond Program	26 N.J.R. 3253(b)	R.1994 d.541	26 N.J.R. 4350(a)
7:5C	Endangered Plant Species Program	26 N.J.R. 3790(a)		
7:5D	State Trails System	26 N.J.R. 1459(a)		
7:7A-16.1	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:9	NJPDES permitting program: proposal summary and request for public comment	26 N.J.R. 3927(a)		
7:9B	NJPDES permitting program: proposal summary and request for public comment	26 N.J.R. 3927(a)		
7:10-15.1	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:12-1.2, 2.1, 3.2, 4.1, 4.2, 9.1	Shellfish growing water classifications	26 N.J.R. 4475(b)		
7:13	Flood hazard area control	26 N.J.R. 1009(a)		
7:13-7.1	Flood plain redelineation of Pascack and Fieldstone brooks in Montvale	26 N.J.R. 2834(a)		
7:14	NJPDES permitting program: proposal summary and request for public comment	26 N.J.R. 3927(a)		
7:14A	New Jersey Pollutant Discharge Elimination System	26 N.J.R. 1332(a)		
7:14A	NJPDES permitting program: proposal summary and request for public comment	26 N.J.R. 3927(a)		
7:14A-1.8	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:14B-3.9	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:15	Statewide Water Quality Management Planning Rules: public meetings and opportunity for comment on draft amendments	26 N.J.R. 792(a)		
7:15	NJPDES permitting program: proposal summary and request for public comment	26 N.J.R. 3927(a)		
7:19-3.8	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:22A	Sewage Infrastructure Improvement Act grants	26 N.J.R. 3793(a)		
7:24A	Dam Restoration and Inland Waters Projects Loan Program	26 N.J.R. 2228(a)		
7:25-4	Implementation of Wild Bird Act of 1991	26 N.J.R. 1040(a)		
7:25-6	1995-96 Fish Code	26 N.J.R. 2835(a)	R.1994 d.577	26 N.J.R. 4611(a)
7:25-6.9	1995-96 Fish Code: administrative correction	26 N.J.R. 3258(a)		
7:25-18.1, 18.4, 18.5, 18.13–18.15	Marine fisheries management: winter flounder, bluefish, weakfish, Atlantic sturgeon, American lobster	26 N.J.R. 4277(b)		
7:25-18.1, 18.5	Directed conch fishery	26 N.J.R. 1931(a)	R.1994 d.615	26 N.J.R. 5011(a)
7:25-24.7, 24.9	Leasing of Atlantic coast bottom for aquaculture	26 N.J.R. 3109(a)		
7:26-1.4	Hazardous waste transportation: informal meeting on draft "10-day in-transit holding rule"	26 N.J.R. 294(a)		
7:26-3A.1, 4.1, 4A.1	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:26A-2.1	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:26B-1.10	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:27-1, 8, 18, 22	Air Operating Permits and Reconstruction Permits: public roundtable on proposed new rules and amendments	26 N.J.R. 793(a)		
7:27-8.11	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:27-15	Motor vehicle enhanced inspection and maintenance program	26 N.J.R. 3258(b)		
7:27-16.1	Control and prohibition of air pollution by VOS	25 N.J.R. 6002(a)		
7:27-16.1, 16.4, 16.8, 16.9, 16.10, 16.17, 16.18	Control and prohibition of air pollution by volatile organic compounds	26 N.J.R. 4478(a)		
7:27-16.3, 16.7, 16.13, 16.17, 16.18	Control and prohibition of air pollution by volatile organic compounds: administrative corrections	———	———	26 N.J.R. 4793(a)
7:27-19	Control and prohibition of air pollution from oxides of nitrogen	26 N.J.R. 3298(a)		
7:27-25.1, 25.3	Oxygenated fuels program	26 N.J.R. 1148(a)		
7:27-25.3	Oxygen program exemptions	26 N.J.R. 3835(a)		
7:27-26	Low Emission Vehicles Program	26 N.J.R. 1467(a)		
7:27-26	Low Emission Vehicles Program: extension of comment period	26 N.J.R. 4482(a)		
7:27-27	Control and prohibition of mercury emissions	26 N.J.R. 1050(a)	R.1994 d.537	26 N.J.R. 4355(a)
7:27A	Air pollution control: civil administrative penalties	26 N.J.R. 3566(a)		
7:27A-3.10	Control and prohibition of air pollution by VOS	25 N.J.R. 6002(a)		
7:27A-3.10	Control and prohibition of mercury emissions	26 N.J.R. 1050(a)		
7:27A-3.10	Motor vehicle enhanced inspection and maintenance program	26 N.J.R. 3258(b)		
7:27A-3.10	Control and prohibition of air pollution from oxides of nitrogen	26 N.J.R. 3298(a)		
7:27B-4	Motor vehicle enhanced inspection and maintenance program	26 N.J.R. 3258(b)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
7:28-3.12	Ionizing radiation-producing machines: application and annual registration renewal fees	26 N.J.R. 3797(a)		
7:28-48	Non-ionizing radiation producing sources: registration fees	25 N.J.R. 5422(a)		
7:28-48	Non-ionizing radiation producing sources: extension of comment period regarding registration fees	26 N.J.R. 793(b)		
7:30-1.1	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:31-1.1	Payment schedule for permit application fees	26 N.J.R. 3922(a)		
7:50-2, 3, 4, 5, 6, 7	Pinelands Comprehensive Management Plan	26 N.J.R. 165(a)	R.1994 d.590	26 N.J.R. 4795(a)
	Most recent update to Title 7: TRANSMITTAL 1994-10 (supplement October 17, 1994)			
HEALTH—TITLE 8				
8:1-1	Disability discrimination grievance procedure	26 N.J.R. 2005(a)		
8:8-8.3, 8.5, 8.8	Collection of human blood	26 N.J.R. 3141(a)		
8:18	Catastrophic Illness in Children Relief Fund Program	26 N.J.R. 3573(a)	R.1994 d.572	26 N.J.R. 4380(a)
8:18	Catastrophic Illness in Children Relief Fund Program: corrections to proposal statements	26 N.J.R. 3805(a)		
8:23	Veterinary public health	26 N.J.R. 4129(a)		
8:23A	Veterinary public health	26 N.J.R. 4129(a)		
8:31	Health facilities construction plan review fee	26 N.J.R. 4135(a)		
8:31B-3.3, 3.70	Health care financing: monitoring and reporting	26 N.J.R. 12(a)		
8:31B-4.37	Charity care audit functions	26 N.J.R. 13(a)		
8:39	Long-term care facilities: standards for licensure	26 N.J.R. 1772(c)	R.1994 d.582	26 N.J.R. 4641(a)
8:39-2.2, 2.12	Long-term care facilities: application for licensure; add-a-bed	26 N.J.R. 4641(a)		
8:43E	Health care facilities: enforcement of licensure standards	26 N.J.R. 4527(a)		
8:43F	Adult day health care facilities: standards for licensure	26 N.J.R. 4532(a)		
8:43G	Hospital licensing standards	26 N.J.R. 4537(a)		
8:44-2.5	Clinical laboratory Proficiency Testing Program	26 N.J.R. 1070(a)		
8:44-2.11	Clinical laboratories: reopening of comment period on reporting of blood lead levels	26 N.J.R. 1190(a)		
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8:57-5	Confinement of persons with tuberculosis: public hearing	26 N.J.R. 3574(a)		
8:59	Worker and Community Right to Know Act rules	26 N.J.R. 2888(a)	R.1994 d.535	26 N.J.R. 4380(b)
8:59-App. A, B	Worker and Community Right to Know Hazardous Substance List	26 N.J.R. 540(a)		
8:62	Certification of lead abatement workers, supervisors, inspectors, project designers	26 N.J.R. 3575(a)		
8:71	List of Interchangeable Drug Products (see 26 N.J.R. 1348(a), 2096(a))	26 N.J.R. 13(b)	R.1994 d.456	26 N.J.R. 3716(a)
8:71	List of Interchangeable Drug Products	26 N.J.R. 14(a)	R.1994 d.244	26 N.J.R. 2039(a)
8:71	List of Interchangeable Drug Products	26 N.J.R. 69(a)	R.1994 d.243	26 N.J.R. 2028(a)
8:71	Interchangeable drug products (see 26 N.J.R. 2025(b), 2901(a), 3715(b))	26 N.J.R. 1190(b)	R.1994 d.546	26 N.J.R. 4387(a)
8:71	Interchangeable drug products (see 26 N.J.R. 2897(a), 3719(a))	26 N.J.R. 1821(a)	R.1994 d.547	26 N.J.R. 4388(a)
8:71	Interchangeable drug products (see 26 N.J.R. 2898(a), 3717(b))	26 N.J.R. 1822(a)	R.1994 d.548	26 N.J.R. 4388(b)
8:71	Interchangeable drug products (see 26 N.J.R. 3720(a))	26 N.J.R. 2723(a)	R.1994 d.545	26 N.J.R. 4386(a)
8:71	Interchangeable drug products	26 N.J.R. 3583(a)	R.1994 d.549	26 N.J.R. 4390(a)
8:71	Interchangeable drug products	26 N.J.R. 4288(a)		
8:71	Interchangeable drug products	26 N.J.R. 4293(a)		
8:71	Interchangeable drug products	26 N.J.R. 4294(a)		
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9:9-7.1, 7.2, 7.3	Eligibility criteria for NJCLASS loans	26 N.J.R. 3242(a)	R.1994 d.617	26 N.J.R. 5012(a)
9:11-1.2, 1.7, 1.8, 1.19, 1.20, 1.22, 1.23	Educational Opportunity Fund Program	26 N.J.R. 3586(a)	R.1994 d.596	26 N.J.R. 4760(b)
9:12-1.1, 1.4, 1.6–1.9, 1.16–1.21, 1.23, 2.5, 2.7, 2.8, 2.10	Educational Opportunity Fund Program	26 N.J.R. 3586(a)	R.1994 d.596	26 N.J.R. 4760(b)
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10:15A	Child Care Services Manual	26 N.J.R. 3327(a)	R.1994 d.628	26 N.J.R. 5012(b)
10:15B	Child Care Services Manual	26 N.J.R. 3327(a)	R.1994 d.628	26 N.J.R. 5012(b)
10:15C	Child Care Services Manual	26 N.J.R. 3327(a)	R.1994 d.628	26 N.J.R. 5012(b)

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10:17	Child placement rights	26 N.J.R. 1563(a)		
10:37-5.28–5.34	Repeal (see 10:37E)	26 N.J.R. 3608(a)		
10:37-5.46–5.51	Repeal (see 10:37F)	26 N.J.R. 4547(a)		
10:37E	Division of Mental Health and Hospitals: outpatient service standards	26 N.J.R. 3608(a)		
10:37F	Adult Partial Care Services for individuals with severe and persistent mental illness	26 N.J.R. 4547(a)		
10:43	Division of Developmental Disabilities: determination of need for guardian	26 N.J.R. 2838(a)	R.1994 d.611	26 N.J.R. 5020(a)
10:43	Division of Developmental Disabilities: extension of comment period concerning determination of need for guardian	26 N.J.R. 3341(a)		
10:46A	Family Support Service System	26 N.J.R. 3341(b)		
10:46A	Family Support Service System: administrative correction and extension of comment period	26 N.J.R. 3610(a)		
10:46B	Division of Developmental Disabilities: placement of eligible persons	26 N.J.R. 3611(a)		
10:48-4	Eligibility for services	26 N.J.R. 1752(a)		
10:48-4	Division of Developmental Disabilities: public hearing and reopening of comment period regarding management of waiting lists for services	26 N.J.R. 2756(a)		
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10:49-14.4	Medical assistance recoveries involving county welfare agencies	26 N.J.R. 3348(a)		
10:50-2.2	Transportation services for Medicaid recipients: provider reimbursement	26 N.J.R. 3929(a)	R.1994 d.622	26 N.J.R. 5020(b)
10:51-1.6, 1.23, 2.6, 2.21, 4.6, 4.22, App. E	Medicaid and Pharmaceutical Assistance to the Aged and Disabled programs: EMC billing	26 N.J.R. 4136(a)		
10:51-1.12	Medicaid reimbursement for infertility-related services	26 N.J.R. 3345(a)	R.1994 d.600	26 N.J.R. 4762(a)
10:51-1.12, 2.11, 4.13	Medicaid and PAAD programs: unit-dose-packaged drugs	26 N.J.R. 3349(a)		
10:52	Manual for Hospital Services	26 N.J.R. 4551(a)		
10:52-1.3, 1.7, 1.8	Medicaid reimbursement for infertility-related services	26 N.J.R. 3345(a)	R.1994 d.600	26 N.J.R. 4762(a)
10:52-8.2	Manual of Hospital Services: disproportionate share adjustment for Other Uncompensated Care component	26 N.J.R. 2239(a)		
10:52-8.2	Charity care component of Health Care Subsidy Fund	26 N.J.R. 3485(a)	R.1994 d.536	26 N.J.R. 4392(a)
10:53-1.6, 1.7	Medicaid reimbursement for infertility-related services	26 N.J.R. 3345(a)	R.1994 d.600	26 N.J.R. 4762(a)
10:54-1.2	Medicaid reimbursement for infertility-related services	26 N.J.R. 3345(a)	R.1994 d.600	26 N.J.R. 4762(a)
10:58-1.3	Medicaid reimbursement for infertility-related services	26 N.J.R. 3345(a)	R.1994 d.600	26 N.J.R. 4762(a)
10:59-1.9	Medical Supplier Manual: reimbursement for certain services	26 N.J.R. 2839(a)		
10:60-1.3	Home Care Services: accreditation of private duty nursing agencies	26 N.J.R. 2840(a)	R.1994 d.623	26 N.J.R. 5021(a)
10:61-1.3, 3.2	Medicaid reimbursement for infertility-related services	26 N.J.R. 3345(a)	R.1994 d.600	26 N.J.R. 4762(a)
10:63	Long-Term Care Services	26 N.J.R. 3614(a)		
10:66-2.3	Medicaid reimbursement for infertility-related services	26 N.J.R. 3345(a)	R.1994. d.600	26 N.J.R. 4762(a)
10:69A-5.3, 5.6, 6.2, 6.12	Pharmaceutical Assistance to the Aged and Disabled: eligibility and income criteria	26 N.J.R. 3142(a)		
10:73-1.1, 1.2, 2.1, 2.6, 2.8–2.12, 3.1, 3.2	Medicaid program: case management services billing	26 N.J.R. 3350(a)	R.1994 d.585	26 N.J.R. 4614(a)
10:81-2.6, 3.9, 3.10, 13.3	Public Assistance Manual: AFDC-N segment eligibility of aliens	26 N.J.R. 3930(a)	R.1994 d.612	26 N.J.R. 5022(a)
10:81-11.6A, 11.6B, 11.15	Child Support Hotline; locator processing fees	26 N.J.R. 3353(a)	R.1994 d.566	26 N.J.R. 4616(a)
10:81-11.9	Public Assistance Manual: $50 disregarded child support payment	26 N.J.R. 1937(a)		
10:82-2.3	Assistance Standards Handbook: AFDC-N segment eligibility of aliens	26 N.J.R. 3932(a)	R.1994 d.613	26 N.J.R. 5022(b)
10:82-3.14	Assistant Standards Handbook: administrative correction regarding guardians of adolescent parents	_____	_____	26 N.J.R. 4765(a)
10:83-1.11	Supplemental Security Income payment levels for 1995	_____	_____	26 N.J.R. 5023(a)
10:85	General Assistance Manual	26 N.J.R. 2757(b)	R.1994 d.591	26 N.J.R. 4765(b)
10:85-4.6	General Assistance Program: extension of temporary rental assistance benefits	26 N.J.R. 1756(a)		
10:87-2.31	Food Stamp Program: applications in pending status	26 N.J.R. 4298(a)		
10:89	Home Energy Assistance Handbook	26 N.J.R. 4726(a)		
10:95	Commission for the Blind and Visually Impaired: Vocational Rehabilitation Services Program	26 N.J.R. 2242(a)	R.1994 d.561	26 N.J.R. 4394(a)
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10:129A	Child protective services investigations and determinations of abuse and neglect	26 N.J.R. 3700(a)		
10:133A-1.7, 1.9, 1.10, 1.11, 1.12	Division of Youth and Family Services: initial reponse	26 N.J.R. 3355(a)		
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11:2-1	Admission requirements for foreign and alien life and health insurers	26 N.J.R. 4586(a)		
11:2-27.3	Determination of insurers in a hazardous financial condition	26 N.J.R. 3589(a)	R.1994 d.550	26 N.J.R. 4407(a)
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11:3-29.4	Automobile insurance PIP and motor bus coverage: administrative correction regarding application of Medical Fee Schedules	———	———	26 N.J.R. 5041(a)
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11:5-1.7	Real Estate Commission: preproposal concerning mass marketing and brokerage licensure requirement	26 N.J.R. 3110(a)		
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11:15-2	Joint insurance funds for local governmental units: extension of comment period	26 N.J.R. 3592(a)		
11:17A	Insurance producers and limited insurance representatives: marketing conduct standards	26 N.J.R. 4307(a)		
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12:18 App.	Department of Labor hearings	26 N.J.R. 2174(a)		
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12:195-1.9	Carnival-amusement rides: inspection and permit fees	26 N.J.R. 3594(a)	R.1994 d.581	26 N.J.R. 4630(a)
12:235-1.6	Workers' Compensation: 1995 maximum benefit rate	26 N.J.R. 3594(b)	R.1994 d.553	26 N.J.R. 4410(b)
12:235-1.6	Workers' Compensation 1995 maximum benefit rate: administrative correction	———	———	26 N.J.R. 5032(a)
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13:13	Housing discrimination	26 N.J.R. 1942(a)		
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13:33-4.1	Board of Ophthalmic Dispensers and Ophthalmic Technicians: contact lens dispensing	26 N.J.R. 1595(a)		

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13:59	State Police: criminal history background checks for non-criminal justice purposes	26 N.J.R. 3595(a)	R.1995 d.601	26 N.J.R. 4782(a)
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13:70-8.18	Thoroughbred racing: items included in jockey's weight	26 N.J.R. 3130(a)	R.1994 d.554	26 N.J.R. 4420(a)
13:70-8.28	Thoroughbred racing: overweight of jockey after race	26 N.J.R. 3130(b)	R.1994 d.555	26 N.J.R. 4420(b)
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13:70-14A.8	Thoroughbred racing: possession of drugs or drug instruments	26 N.J.R. 1315(a)		
13:70-14A.9	Thoroughbred racing: administration of phenylbutazone on day of race	26 N.J.R. 1956(a)		
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