

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

**Authority**

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

**Source and Effective Date**

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

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

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

**Chapter Historical Note**

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

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

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

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

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

Subchapter 13, Group Student Health Insurance, was adopted as R.1977 d.309, effective August 22, 1977. See: 9 N.J.R. 343(c), 9 N.J.R. 438(d).

Subchapter 14, Home Health Care Insurance Coverage, was adopted as R.1977 d.476, effective December 15, 1977. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

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

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

Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings, were adopted as new rules by R.1980 d.176, effective April 21, 1980. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c).

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

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

Subchapter 2, Replacement of Life Insurance Policy, was repealed and Subchapter 2, Replacement of Life Insurance Policy, was adopted as new rules by R.1982 d.16, effective February 1, 1982, operative June 1, 1982.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

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

Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables, was adopted as R.1984 d.478, effective November 5, 1984. See: 16 N.J.R. 1452(a), 16 N.J.R. 3040(a).

Pursuant to Executive Order No. 66(1978), Subchapter 6, Reserve Standards for Individual Health Insurance Policies, was readopted as R.1984 d.512, effective November 5, 1984. See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Subchapter 23, Medicare Supplement Policies and Contracts, was adopted as R.1985 d.70, effective February 19, 1985, operative June 19, 1985. See: 16 N.J.R. 2945(a), 17 N.J.R. 460(a).

Pursuant to Executive Order No. 66(1978), Subchapter 20, Blindness; Partial Blindness or Other Physical or Mental Impairments; Unfair Discrimination, was readopted as R.1985 d.161, effective April 1, 1985. See: 17 N.J.R. 168(a), 17 N.J.R. 820(a).

Pursuant to Executive Order No. 66(1978), Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings were readopted as R.1985 d.221, effective April 15, 1985. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a).

Subchapter 21 was readopted as R.1985 d.325, effective June 3, 1985. See: 17 N.J.R. 891(a), 17 N.J.R. 1660(a).

Subchapter 24, Smoker and Nonsmoker Mortality Tables, was adopted as R.1985 d.617, effective December 2, 1985. See: 17 N.J.R. 2348(a), 17 N.J.R. 2907(a).

Subchapter 26, Annuity Mortality Tables, was adopted as R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 290(a).

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

Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, was adopted as R.1988 d.455, effective September 19, 1988. See: 20 N.J.R. 43(a), 20 N.J.R. 2377(c).

Subchapter 28, Group Coordination of Benefits, was adopted as new rules by R.1988 d.499, effective October 17, 1988. See: 20 N.J.R. 1773(b), 20 N.J.R. 2581(a).

Subchapter 29, Homeowners Comparison Survey, was adopted as R.1989 d.50, effective January 17, 1989. See: 20 N.J.R. 2181(a), 21 N.J.R. 164(a).

Subchapter 31, Term Life Insurance Comparison Survey, was adopted as R.1989 d.122, effective February 21, 1989. See: 20 N.J.R. 2990(a), 21 N.J.R. 566(a).

Subchapter 32, Health Service Corporation Notice of Increased Rates, was adopted as R.1989 d.522, effective October 2, 1989. See: 21 N.J.R. 973(b), 21 N.J.R. 3173(c).

Subchapter 33, Excess Interest Reserve Adjustment, was adopted as R.1989 d.523, effective October 2, 1989. See: 21 N.J.R. 1308(a), 21 N.J.R. 3175(c).

Subchapter 34, Long-Term Care Insurance, was adopted as R.1989 d.571, effective November 6, 1989. See: 21 N.J.R. 1964(a), 21 N.J.R. 3465(a).

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

Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1991 d.3, effective November 30, 1990, Subchapter 1, Contracts on a Variable Basis, was repealed by R.1991 d.3, effective January 7, 1991. See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).

Subchapter 35, Annual Medicare Supplement Policy Survey, was adopted as R.1991 d.122, effective March 4, 1991. See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a).

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

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

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

Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures, was adopted as R.1995 d.406, effective August 7, 1995. See: 27 N.J.R. 1356(b), 27 N.J.R. 2931(a).

Subchapter 30, Accelerated Death Benefits, was adopted as R.1995 d.521, effective September 18, 1995. See: 27 N.J.R. 2046(a), 27 N.J.R. 3613(c).

Subchapter 40, Life/Health/Annuity Forms, was adopted as R.1995 d.569, effective November 6, 1995. See: 27 N.J.R. 2857(a), 27 N.J.R. 2867(a), 27 N.J.R. 4317(a).

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

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.1996 d.4, effective November 30, 1995, and Subchapter 5, Amendment to Instructions to Life and Accident and Health Annual Statement Blank, Subchapter 10, Expense Experience, Subchapter 32, Health Service Corporation Notice of Increased Rates, Subchapter 35, Annual Medicare Supplement Policy Survey, and Exhibits A and B of the Appendix to Subchapters 16 and 23 were repealed by R.1996 d.4, effective January 2, 1996. See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subchapter 54, Benefit Standards for Infertility Coverage, was adopted as new rules by R.2003 d.160, effective April 21, 2003. See: 34 N.J.R. 2521(a), 35 N.J.R. 1692(b).

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<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
95	317.32	317.32
96	375.74	375.74
97	474.97	474.97
98	655.85	655.85
99	1000.00	1000.00

**SUBCHAPTER 23. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT COVERAGE**

**11:4-23.1 Purpose**

This subchapter provides for the reasonable standardization of coverage and the simplification of terms and benefits of Medicare supplement policies; facilitates comparison of such policies in order to increase public understanding; eliminates provisions which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and provides for full disclosure in the sale of health care service benefits and insurance to persons eligible for Medicare.

Amended by R.1991 d.345, effective July 1, 1991.  
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted “, contracts and certificates issued on a group basis”, “public understanding and”, “and contracts”, “contained in such policies”, “and service corporation coverages”; added “in order to increase public understanding”, “of such policies”, “care service benefits and”.

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

Deleted “by reason of age.”

**11:4-23.2 Applicability and scope**

(a) This subchapter shall apply to:

1. All Medicare supplement policies, as defined by this subchapter, delivered or issued for delivery in this State;
2. All certificates, as defined by this subchapter, issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State.

(b) This subchapter shall apply to all carriers, as defined in this subchapter, delivering or issuing for delivery Medicare supplement policies in this State, or delivering or issuing for delivery certificates in this State, which certificates were issued under a group Medicare supplement policy.

Amended by R.1991 d.345, effective July 1, 1991.  
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Added “in N.J.A.C. 11:4-23.8 and 23.9” in (a).

Deleted “group”, “and individual and group subscriber Medicare Supplement contracts”; added “as defined by this subchapter”; changed “the effective date” to “July 1, 1991” in (a)1.

Deleted “Supplement”, “or subscriber contracts”, “policies or contracts”; added “as defined by this subchapter”, “supplement”, “certificates”, “on or after July 1, 1991” in (a)2.

Deleted (b).  
Amended by R.1993 d.26, effective January 4, 1993.  
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).  
Certificates delivered or issued for delivery in New Jersey added.

**11:4-23.3 Definitions**

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

“Aggregate loss ratio” means the ratio of the accumulated value of past benefits (from the original effective date of the form to the date as of which the ratio is determined) and the present value of future benefits to the accumulated value of past premiums (from the original effective date of the form to the date as of which the ratio is determined) and the present value of future premiums. Benefits shall not be increased nor premiums reduced by actual or anticipated dividends, and interest shall be included in the accumulated and present values on the same basis as in the present values of the anticipated loss ratio.

“Anticipated loss ratio” means the ratio of the present value of the expected benefits, not including dividends, to the present value of the expected premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. For purposes of this ratio, the present values must incorporate realistic rates of interest which are determined before Federal taxes but after investment expenses. Benefits and premiums shall be discounted from the year of payment, with reasonable assumptions as to time of payment within the year.

“Applicant” means:

1. In the case of a group policy, the proposed certificate holder;
2. In the case of an individual policy, the person who seeks to contract for coverage.

“Bankruptcy” means when a Medicare + Choice organization that is not a carrier has filed, or has had filed against it, a petition for declaration of bankruptcy pursuant to the United States Bankruptcy Code, 11 U.S.C. §§ 101 et seq. and has ceased doing business in the State.

“Carrier” means any person who contracts to provide health services, reimburse the cost of health services in whole or in part, or provide an indemnity in the event that health services are used, in return for a prepaid or postpaid premium or other consideration, including insurance companies, fraternal benefit societies, hospital, medical and health service corporations, health maintenance organizations and such other similar entities.

“Certificate” means any certificate or other document which sets forth or summarizes the essential features of the coverage issued under a group policy, which certificate or

other document has been delivered or issued for delivery in this State.

“Certificate form” means the form on which a certificate is delivered or issued for delivery by a carrier.

“Continuous period of creditable coverage” means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

“Coverage” means:

1. Any arrangement whereby a carrier agrees to indemnify or reimburse an individual or group member for some portion or part of the health related costs incurred by that individual or member, subject to the terms of the written agreement and law; and

2. Any arrangement whereby a carrier agrees to provide direct or indirect health care services to the individual or group member, subject to the terms of the written agreement and law.

“Creditable coverage” means, with respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health benefit plan as defined in Federal regulations; and
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

“Creditable coverage” shall not include one or more, or any combination of the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers’ compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics; and
8. Other similar insurance coverage, specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

“Creditable coverage” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;
2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
3. Such other similar, limited benefits as are specified in Federal regulations.

“Creditable coverage” shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Hospital indemnity or other fixed indemnity insurance.

“Creditable coverage” shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplement health insurance as defined under section 1882(g)(1) of the Social Security Act;
2. Coverage supplemental to the coverage provided under chapter 55 of Title 10 United States Code; and
3. Similar supplemental coverage provided to coverage under a group health plan.

“Employee welfare benefit plan” means a plan, fund or program of employee benefits as defined in 29 U.S.C. § 1002 (Employee Retirement Income Security Act).

“Insolvency” or “insolvent” means:

1. That a carrier:
  - i. Is unable to pay its obligations when they are due; or
  - ii. Its admitted assets do not exceed its liabilities plus the greater of:
    - (1) Any capital and surplus required by law for its organization; or
    - (2) The total par or stated value of its authorized and issued capital stock.

2. For purposes of the definition of “insolvency” or “insolvent,” “liabilities” shall include, but not be limited to, reserves required by law or by regulations of the New Jersey Department of Banking and Insurance (Department) or specific requirements imposed by the Commissioner of the Department upon a carrier at the time of admission or subsequent thereto.

“Insured” means any applicant provided coverage by a carrier.

“Medicare+Choice plan” means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 of Title IV, Subtitle A, Chapter 1 of P.L. 105-33 (42 U.S.C. § 1395w-28), and includes:

1. Coordinated care plans which provide health care services, including, but not limited to, health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

3. Medicare+Choice private fee-for-service plans.

“Medicare supplement policy” means a group or individual policy which is advertised, marketed or designed primarily as, or is otherwise held out to be a supplement to reimbursements under Medicare, other than a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. § 1395 et seq.), or a contract or policy issued under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1). This term does not include a policy or certificate of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or combination thereof, of the labor organization.

“Months exposed” means, for a given calendar period, the sum of the number of months an insured was covered for all insureds during that period.

“Policy” shall mean any policy, contract, certificate or other document which sets forth or summarizes the essential features of the coverage issued to an individual or group by a carrier, for the purpose of providing Medicare supplement coverage, including any such policy issued pursuant to a conversion privilege to an individual 65 years of age or older, except as otherwise provided in this subchapter or Federal law.

“Policy form” means the form on which a policy is delivered or issued for delivery by a carrier.

“Secretary” means the Secretary of the United States Department of Health and Human Services.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted “Medicare supplement” in “applicant” 1.

Deleted “Medicare supplement subscriber contract”, “hospital or medical service benefits,”; added “policy”, “coverage” in “applicant” 2.

Deleted “applicant” 3.

Deleted “:1. Any”, “Medicare Supplement”, “policy”; added “or other document which sets forth or summarizes the essential features of the coverage”, “certificate or other document” in “Certificate” 1.

Deleted “Certificate” 2.

Added “Coverage”.

Deleted “:1.A”, “accident and sickness insurance”, “:i.A”; deleted lii and iii in “Medicare supplement policy”.

Deleted “Medicare supplement policy” 2.

Added “Policy”.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Added definitions for aggregate loss ratio, anticipated loss ratio, carrier, certificate form and policy form; deleted definition of, and references to, insurer.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended “Medicare supplement policy”.

Emergency amendment R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Inserted “Bankruptcy”, “Employer welfare benefit plan”, “Insolvency” or “insolvent”, “Medicare+Choice plan” and “Secretary”.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

Amended by R.1999 d.161, effective May 17, 1999.

See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

Inserted “Continuous period of creditable coverage” and “Creditable coverage”.

Amended by R.2004 d.246, effective July 6, 2004.

See: 35 N.J.R. 2562(a), 36 N.J.R. 3292(a).

Added “Months exposed”.

#### 11:4-23.4 Policy definitions and terms

(a) No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

1. “Accident,” “accidental injury,” or “accidental means” shall be defined to employ “result” language and shall not include words which establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization.

i. “Injury” shall not be defined more restrictively than as a bodily injury sustained by the covered person as a result of an accident, which injury is the direct cause of the loss, independent of disease, bodily infirmity or any other cause, and which occurs while coverage is in force.

ii. The definition may provide that injuries shall not include injuries for which benefits are provided under any workers’ compensation, employer’s liability or similar law, mandatory motor vehicle no-fault plan, unless prohibited by law.

2. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

3. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined by the Medicare program.

4. "Health care expenses" means expenses of health maintenance organizations which expenses are associated with the delivery of health care services and are analogous to incurred losses of insurers. Expenses shall not include the following costs:

- i. Home office and overhead costs;
- ii. Advertising costs;

iii. Commissions and other acquisition costs;

iv. Taxes;

v. Capital costs;

vi. Administrative costs; and

vii. Claims processing costs.

5. "Hospital" may be defined in relation to its status, facilities, and available services or to reflect accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined by the Medicare program.

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

7. "Medicare eligible expense" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

8. "Physician" shall not be defined more restrictively than as defined by the Medicare program.

9. "Preexisting condition" shall not be defined more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

10. "Sickness" shall not be defined more restrictively than a sickness or disease which causes loss commencing while the insurance or coverage is in force and which is not excluded under a preexisting condition limitation. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

11. "Totally disabled" shall not be defined more restrictively than as:

- i. An injury or sickness that continuously confines an individual in a hospital or skilled nursing facility; or
- ii. A continuous disability resulting from an injury or sickness not requiring confinement of an individual in a hospital or skilled nursing facility, but which a physician certifies as preventing that individual from engaging in the normal activities of a person of like age and sex in good health.

Amended by R.1991 d.345, effective July 1, 1991.  
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted "group insurance", "or individual or group subscriber contract", "Supplement", "or subscriber contract" in (a).

Deleted "the definition of injury", "an accidental", "insurance or service corporation"; added "Injury", "defined", "as a result of an accident", "injury" in (a)1i.

Deleted ", or injuries occurring while the covered person is engaged in any activity pertaining to any trade, or business, employment, or occupation for wage or profit" in (a)1ii.

Deleted "or hospital or medical service corporations", "may", "as are applicable to Medicare claims"; added "shall", "as are applicable to Medicare claims" in (a)1ii6.

Deleted "or hospital or medical service corporation" in (a)1ii8 and 9.  
Added (a)1ii12.

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

Added definition for health care expenses and references to Medicare standards.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

#### 11:4-23.5 Policy provisions

(a) No policy or certificate shall be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy if the policy or certificate contains limitations or exclusions that are more restrictive than those of Medicare, except with respect to preexisting condition limitations.

(b) No Medicare supplement policy or certificate shall provide benefits which duplicate benefits provided by Medicare.

(c) No Medicare supplement policy or certificate shall use waiver endorsements or riders to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted "Medicare Supplement", "may", "such policy"; added "shall", "as a Medicare supplement policy", "it" in (a).

Added "outside the United States" in (a)10.

Changed "Supplement" to "supplement" and "may" to "shall" in (b), (c) and (d); added "endorsements or riders" to (d).

Added (e).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule amended to conform to Medicare standards.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

#### 11:4-23.6 General minimum benefit standards

(a) No policy or certificate shall be advertised, solicited, or issued for delivery in this State as a Medicare supplement policy if it does not meet the minimum standards contained in this section.

(b) The following general standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this subchapter.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred as a result of a preexisting condition after six months from the effective date of coverage, nor shall a preexisting condition be defined more restrictively than as set forth at N.J.A.C. 11:4-23.4(a)9.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amounts and copayment percentage factors, if any, in response to which premiums may be correspondingly modified subject to the requirements of N.J.A.C. 11:4-23.11.

4. A Medicare supplement policy or certificate shall not:

- i. Provide for termination of coverage of an eligible spouse because of termination of coverage of the insured other than for nonpayment of premium; or
- ii. Provide for termination of a covered persons' coverage by the carrier solely on the grounds of age or deterioration of health.

5. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the covered person limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

6. Existing Medicare supplement policies and certificates shall be appropriately amended or endorsed to eliminate benefit duplications with Medicare which are caused by Medicare benefit changes. Any riders or endorsements shall specify the benefits deleted, or shall otherwise result in a clear description of the Medicare supplement benefits provided by the policy. Such riders or endorsements shall be submitted for filing by the Commissioner.

(c) A carrier shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation. With respect to terminations of group policies, or membership in a group, the following standards shall apply:

1. If a group policyholder terminates the group Medicare supplement policy without replacing that policy as provided in (c)3 below, the carrier shall offer individuals covered under group policies at least the following two coverage choices:

- i. An individual guaranteed renewable Medicare supplement policy which provides for continuation of the benefits contained in the group policy; and
- ii. An individual Medicare supplement policy which provides only benefits that otherwise are required to meet N.J.A.C. 11:4-23.8.

2. If membership in a group is terminated, the carrier shall:

- i. Offer the individual whose membership is terminated the conversion opportunities described in (c)1 above; or
- ii. Offer the individual whose membership is terminated continuation of coverage under the group policy, but only at the option of the group policyholder.

3. If a group policyholder replaces one group Medicare supplement policy by another group Medicare supplement policy, the carrier issuing the replacement coverage shall offer coverage to all persons who were covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusions for preexisting conditions that would have been covered under the group policy which was replaced.

Amended by R.1988 d.587, effective December 19, 1988 (operative January 1, 1989).

See: 20 N.J.R. 2510(a), 20 N.J.R. 3155(c).

Added (b)6.-10.; (c)1 and renumbered (c)1.-4. as i.-iv.; added (c)2. Amended by R.1991 d.121, effective March 4, 1991.

See: 22 N.J.R. 771(a), 23 N.J.R. 690(c).

In (b)7: revised internal references to chapter.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted "group insurance", "For individual or group subscriber contract may", "which"; added "shall", "if it" in (a).

Added "nor shall a preexisting condition be defined more restrictively than as set forth at N.J.A.C. 11:4-23.4(a)11." in (b) with stylistic change.

Added "in response to which premiums may be correspondingly modified subject to the requirements of N.J.A.C. 11:4-23.8" in (b)3.

Deleted "or subscriber" in (b)4i.

Deleted "For hospital or medical service corporation" in (b)4ii.

Deleted (b)6, 7, 9, 10.

Recodified existing (b)8 as 6; deleted "commissioner for filing with 45 days after the effective dates of Medicare benefit changes".

Added (c) and (d).

Recodified existing (c) as (e); recodified existing (c)1i, ii, iii, iv as (e)2, 3, 4, 6.

Deleted "For policies issued prior to January 1, 1989;"; added "coverage for either all or none of the Medicare Part A in-patient hospital deductible amount;"; in recodified (e)1.

Added (e)5, 7.

Deleted "of \$200.00 of such expenses and to a maximum calendar year benefit of at least \$5,000."; added "regardless of hospital confinement", "amount equal to the Medicare Part B" in recodified (e)6.

Deleted (c)2.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

General standards for policies and certificates delineated, references to insurer changed to "carrier."

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

#### **11:4-23.7 Minimum benefits for policies and certificates delivered or issued for delivery prior to January 4, 1993**

(a) All policies delivered or issued for delivery in this State prior to January 4, 1993, and all certificates delivered or issued for delivery in this State on or after July 15, 1991 but prior to January 4, 1993 as a Medicare supplement policy or certificate, shall meet the minimum standards set forth at N.J.A.C. 11:4-23.6 in addition to the minimum standards set forth below. The standards of N.J.A.C. 11:4-23.6 and those below are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(b) Benefit conversion requirements for the transition of policy compliance between the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) and the Medicare Catastrophic Coverage Repeal Act of 1989 (P.L. 101-234) are as follows:

1. Effective January 1, 1990, no Medicare supplement policy in force in this State shall contain benefits provided by Medicare.

2. Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

3. For Medicare supplement policies subject to the minimum standards adopted by this State pursuant to the Medicare Catastrophic Coverage Act of 1988, and all policies and certificates delivered or issued for delivery on or after April 16, 1990 but prior to January 4, 1993, the minimum benefit standards for Medicare supplement policies are:

i. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

ii. Coverage of the Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

iii. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

iv. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

v. Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations or already paid for under Part B;

vi. Coverage of Part B Medicare eligible expenses to the extent not covered by Medicare regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible;

vii. Coverage under Medicare Part B for the reasonable cost of the first three pints (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(c) Medicare supplement policies shall be guaranteed renewable.

New Rule, R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on Standards for claims payment recodified to 23.10.

#### 11:4-23.8 Minimum benefit standards for policies and certificates delivered or issued for delivery on or after January 4, 1993.

(a) No policy or certificate shall be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy on or after January 4, 1993 unless it complies with the standards of N.J.A.C. 11:4-23.6 and the benefit standards set forth below.

(b) Medicare supplement policies shall be guaranteed renewable.

(c) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act (42 U.S.C. § 1396-v-end), but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date that the individual becomes entitled to that assistance.

1. If suspension occurs and if the policyholder or certificateholder loses entitlement to Title XIX medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of the termination of the entitlement) if the policyholder or certificateholder provides notice of their loss of the entitlement to the Title XIX assistance within 90 days after the date of that loss and the policyholder or certificateholder pays the premium attributable to the period subsequent to the date of the termination of the entitlement.

2. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by Federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act, 42 U.S.C. § 426(b), and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act, 42 U.S.C. § 1395y(b)(1)(A)(v)). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period from the date of the termination of their enrollment in the group health plan.

3. Reinstatement of coverage as described in (c)1 and 2 above shall:

i. Not impose any waiting period with respect to treatment of preexisting conditions;

ii. Provide for coverage which is substantially equivalent to the coverage that was in effect before the date of the suspension; and

iii. Provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(d) All carriers delivering or issuing for delivery in this State Medicare supplement policies or certificates of group Medicare supplement policies shall offer to all applicants a policy or certificate providing only the core benefits defined at (g) below. A policy or certificate providing only core benefits shall be designated as standardized Medicare supplement benefit plan A.

(e) Carriers may offer to all applicants policies or certificates providing the core benefits and additional benefits defined at (g) below. Only those additional benefits defined at (g) below may be included in Medicare supplement policies or certificates delivered or issued for delivery in this State. Policies or certificates providing additional benefits shall be structured and designated as follows:

1. Standardized Medicare supplement benefit plan B shall provide:

- i. The Core Benefit; and
- ii. The Medicare Part A Deductible benefit.

2. Standardized Medicare supplement benefit plan C shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medicare Part B Deductible benefit; and
- v. The Medically Necessary Emergency Care in a Foreign Country benefit.

3. Standardized Medicare supplement benefit plan D shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- v. The At-Home Recovery Benefit.

4. Standardized Medicare supplement benefit Plan E shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medically Necessary Emergency Care in a Foreign Country benefit; and

v. The Preventive Medical Care benefit.

5. Standardized Medicare supplement benefit Plan F shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medicare Part B Deductible benefit;
- v. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit; and
- vi. The Medically Necessary Emergency Care in a Foreign Country benefit.

6. Standardized Medicare supplement benefit high deductible plan F shall include 100 percent of covered expenses following the payment of the annual high deductible plan "F" deductible, and shall provide: the Core Benefit; the Medicare Part A Deductible benefit; the Skilled Nursing Facility Care benefit; the Medicare Part B Deductible benefit; the One Hundred Percent (100%) of the Medicare Part B Excess Charges benefit; and the Medically Necessary Emergency Care in a Foreign Country benefit. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be \$1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.00.

7. Standardized Medicare supplement benefit plan G shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Eighty Percent (80%) of the Medicare Part B Excess Charges benefit;
- v. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- vi. The At-Home Recovery Benefit.

8. Standardized Medicare supplement benefit plan H shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;

iv. The Basic Outpatient Prescription Drug Benefit; and

v. The Medically Necessary Emergency Care in a Foreign Country benefit.

9. Standardized Medicare supplement benefit plan I shall provide:

i. The Core Benefit;

ii. The Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit;

v. The Basic Outpatient Prescription Drug Benefit; and

vi. The Medically Necessary Emergency Care in a Foreign Country benefit; and

vii. The At-Home Recovery Benefit.

10. Standardized Medicare supplement benefit plan J shall provide:

i. The Core Benefit;

ii. The Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The Medicare Part B Deductible benefit;

v. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit;

vi. The Extended Outpatient Prescription Drug Benefit;

vii. The Medically Necessary Emergency Care in a Foreign Country benefit;

viii. The Preventive Medical Care benefit; and

ix. The At-Home Recovery Benefit.

11. Standardized Medicare supplement benefit high deductible plan J shall provide 100 percent of covered expenses following the payment of the annual high deductible plan J deductible, and shall provide: the Core Benefit; the Medicare Part A Deductible benefit; the Skilled Nursing Facility Care benefit; the Medicare Part B Deductible benefit; the One Hundred Percent (100 percent) of the Medicare Part B Excess Charges Benefit; the Extended Outpatient Prescription Drug Benefit; the Medically Necessary Emergency Care in a Foreign Country benefit; the Preventive Medical Care Benefit; and the At-Home Recovery Benefit. The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1,500 for 1998 and 1999, and shall be

based on a calendar year. It shall be adjusted annually thereafter by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.00.

(f) No groupings, packages or combinations of Medicare supplement benefits shall be offered which differ from the standardized Medicare supplement benefit plans specified in (d) and (e) above, except as an Innovative Benefit which may be approved by the Commissioner. Benefit plans shall be uniform in structure, language, designation and format to the standardized Medicare supplement benefit plans A, B, C, D, E, F, G, H, I and J as set forth in (d) and (e) above. For purposes of this section, "structure," "language," and "format" means style, arrangement and overall content of a benefit.

(g) The following terms and phrases, as used in this section, shall have the following meanings:

1. "At-Home Recovery Benefit" means coverage for services to provide short term, at-home assistance with activities of daily living for persons recovering from an illness, injury or surgery. At-home recovery services shall be services which are designed primarily to assist with activities of daily living.

i. The insured's attending physician shall certify that the specific type and frequency of at-home recovery services prescribed are necessary due to a condition for which a home care plan of treatment was approved by Medicare.

ii. Coverage shall be limited to:

(1) The number and type of at-home recovery visits certified as necessary by the insured's attending physician, received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit, the total number of which shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(2) Care furnished on a visiting basis in the insured's home by a care provider as defined at (g)1v below for up to seven visits in any one week; and

(3) Actual charges up to \$40.00 per visit to a maximum per calendar year benefit of \$1,600.

iii. Coverage shall be excluded for home care visits reimbursed by Medicare or other government programs and for care provided by family members, unpaid volunteers, or providers who do not otherwise meet the definition of a care provider, to the extent Medicare would exclude coverage for care provided by such individuals.

iv. Activities of daily living shall include, but not be limited to, bathing, dressing, personal hygiene, eating, ambulating, assistance with drugs that are normally self-administered, and changing of bandages or other dressings.

v. A care provider shall be a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or a licensed nurses registry.

vi. Any place used by the insured as a place of residence shall be the insured's home, provided that such place would qualify as a residence for home health care services under Medicare. A hospital or skilled nursing facility shall not be considered the insureds' place of residence.

vii. An at-home recovery visit shall be that period of a visit required to provide at-home recovery care. The duration of any such visit shall not be limited, but each consecutive four hours in a 24 hour period of services provided by a care provider shall constitute one visit for purposes of this section.

2. "Basic Outpatient Prescription Drug Benefit" means coverage for 50 percent of outpatient prescription drug charges to the extent not covered by Medicare, subject to a \$250.00 calendar year deductible and a maximum per calendar year benefit per insured of \$1,250.

3. "Core Benefit" means coverage of:

i. Medicare Part A eligible expenses for hospitalization from the 61st day through the 90th day in any Medicare benefit period, to the extent not covered by Medicare;

ii. Medicare Part A eligible expenses for hospitalization for each Medicare lifetime inpatient reserve day used, to the extent not covered by Medicare;

iii. Medicare Part A eligible expenses for hospitalization upon exhaustion of Medicare hospital inpatient coverage, including lifetime reserve days, up to a maximum lifetime benefit of 365 days, to be paid at the Diagnostic Related Group (DRG) outlier per diem, or other appropriate standard of payment as set forth by the Health Care Financing Administration of the United States Department of Health and Human Services for Medicare payments when DRG day outlier payment is not appropriate;

iv. The reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by Federal regulations) under Medicare Parts A and B, unless replaced in accordance with Federal regulation; and

v. The coinsurance amount or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare Part B eligible expenses (generally 20 percent of the approved amount; 50 percent of the approved charges for outpatient psychiatric services), regardless of hospital confinement, subject to the Medicare Part B deductible.

4. "Eighty Percent (80%) of the Medicare Part B Excess Charges" means coverage for 80 percent of the difference between the Medicare-approved Part B charge and the actual Medicare Part B charge billed, up to but not exceeding any charge limitation established by the Medicare program or this State's law, if any.

5. "Extended Outpatient Prescription Drug Benefit" means coverage for 50 percent of outpatient prescription drug charges to the extent not covered by Medicare, subject to a \$250.00 deductible per calendar year, and a maximum per calendar year per insured benefit of \$3,000.

6. "Innovative Benefits" means benefits that are in addition to the benefits specified for standardized Medicare supplement benefit plans A, B, C, D, E, F, G, H, I and J, that are appropriate to Medicare supplement insurance and do not duplicate any benefit provided by Medicare, and that are otherwise unavailable, cost effective, and offered in a manner consistent with simplification of Medicare supplement policies. No carrier shall include an Innovative Benefit in a policy or certificate offered for delivery in this State without the prior approval of the Commissioner.

7. "Medically Necessary Emergency Care in a Foreign Country" means coverage of 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if received in the United States, and which care began during the first 60 consecutive days of each trip outside the United States, to the extent billed charges are not covered by Medicare, and subject to a calendar year deductible of \$250.00 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

8. "Medicare Part A Deductible" means coverage of all of the Medicare Part A inpatient hospital deductible amount per benefit period.

9. "Medicare Part B Deductible" means coverage of all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

10. "One Hundred Percent (100%) of the Medicare Part B Excess Charges" means coverage for all of the difference between the Medicare Part B approved charge and the actual Medicare Part B billed charge, up to but not exceeding any charge limitation established by the Medicare program or this State's law, if any.

11. "Preventive Medical Care Benefit" means coverage of the following services not otherwise covered by Medicare in the calendar year for the actual charges up to 100 percent of the Medicare-approved amount for each service (as if Medicare were to cover the service as identified in the American Medical Association Current Procedural Terminology Codes), subject to a maximum benefit of \$120.00 per calendar year:

i. An annual clinical preventive medical history and physical examination that shall include patient education to address preventive health care measures and any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

- (1) Fecal occult blood test and/or digital rectal examination;
- (2) Mammogram;
- (3) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria;
- (4) Pure tone (air only) hearing screening test administered or ordered by a physician;
- (5) Serum cholesterol screening (every five years);
- (6) Thyroid function test; and
- (7) Diabetes screening;

ii. Influenza vaccine administered at any appropriate time during a calendar year;

iii. Tetanus and diphtheria booster (every 10 years); and

iv. Other tests or preventive measures determined appropriate by the attending physician.

12. "Skilled Nursing Facility Care" means coverage for the actual billed charges up to the Medicare coinsurance amount from the 21st day through the 100th day in a Medicare benefit period, for posthospital skilled nursing facility care eligible under Medicare Part A.

New Rule, R.1993 d.26, effective January 4, 1993.  
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on loss ratio standards recodified to 23.11; new rule added on minimum benefit standards for policies and certificates delivered or issued for delivery on or after the effective date of this subchapter. Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).  
Amended by R.1999 d.161, effective May 17, 1999.  
See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

In (e), inserted a new 6, recodified former 6 through 9 as 7 through 10, and added 11; and in (g)3v, inserted "(or in the case of hospital outpatient department services under a prospective payment system, the copayment amount)".

Amended by R.2003 d.220, effective May 19, 2003.  
See: 35 N.J.R. 71(a), 35 N.J.R. 2184(a).

Rewrote (c); in (g), substituted "services paid under" for "services under" preceding "a prospective payment system" in 3v.

#### Case Notes

Under regulations adopted by Department of Banking and Insurance (DOBI), payment made by the patient's Medigap insurer to hospital

utilizing the diagnostic related group (DRG) reimbursement formula established by Health Care Financing Administration was full payment of the carrier's obligation to the hospital. *Valley Hospital v. Kroll*, 847 A.2d 636.

Hospital seeking to collect balance of patient's bill representing gap between its "standard" charges and benefits paid to it by Medicare and patient's Medigap insurance could not charge patient more than Medicare rate, and thus could not balance bill patient for services he received post-Medicare, as New Jersey's regulatory scheme barred balance billing of Medigap patients, and exposing the elderly or their estates to liability for amounts that a hospital's rate exceeded the Medicare-approved rate was at odds with the goal of Medigap insurance. *Valley Hospital v. Kroll*, 847 A.2d 636.

Interpretation of New Jersey regulation as prohibiting hospital from billing patient for gap between its "standard" charges, and benefits paid to it by Medicare and patient's Medigap insurance, was not preempted by federal law, as Medicare Act and associated regulations contained no express preemption provision, and New Jersey's regulatory scheme regulated an area within the traditional realm of state police power. *Valley Hospital v. Kroll*, 847 A.2d 636.

#### 11:4-23.9 Open enrollment

(a) Carriers shall not deny or condition the effectiveness or issuance, nor discriminate in the pricing, of Medicare supplement policies or certificates based on the health status, claims experience, receipt of health care by, or medical condition of an applicant if the application is submitted for Medicare supplement coverage prior to or during the six month period beginning with the first day of the first month in which the applicant is 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate shall be made available to all applicants who qualify under this section without regard to age.

(b) If an applicant qualifies under (a) above and submits an application during the time period referenced in (a) above and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the carrier shall not exclude benefits based on a preexisting condition.

(c) If the applicant qualifies under (a) above and submits an application during the time period referenced in (a) above and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the carrier shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date.

(d) Except as provided in N.J.A.C. 11:4-23.15(d) and in (b) and (c) above, nothing in (a) above shall be construed to prohibit or limit a carrier's use of permissible preexisting condition exclusion provisions in any Medicare supplement policy or certificate as set forth in this subchapter.

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

Rule on filing requirements recodified to 23.12; new rule added on open enrollment.

Amended by R.1996 d.295, effective July 1, 1996.  
See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.1999 d.161, effective May 17, 1999.  
See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

Inserted new (b) and (c); and recodified former (b) as (d), and inserted "and in (b) and (c) above" following "N.J.A.C. 11:4-23.15(d)".

#### 11:4-23.10 Standards for claims payment

(a) Every carrier providing Medicare supplement policies and certificates shall comply with Section 1882(c)(3) of the Social Security Act as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) by:

1. Acceptance of notice from a Medicare-Carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits under the Medicare supplement policy or certificate as sufficient claim notice without requiring other or additional claims forms to be submitted, and making a payment determination based on the information contained in the notice from the Medicare-Carrier;
2. Notification of the participating physician or supplier, and the beneficiary, of the payment determination, and making payment directly to the participating physician or supplier;
3. Providing each enrollee, at the time of enrollment, a card listing the policy name, policy number, and a mailing address to which notices from a Medicare-Carrier may be sent;
4. Payment of user fees for claim notices that are transmitted electronically or otherwise; and
5. Providing to the Secretary of Health and Human Services at least annually, a central mailing address to which all claims may be sent by the Medicare-Carrier.

(b) Compliance with the requirements set forth in (a) above shall be certified on the Medicare supplement experience reporting form.

(c) Payment of benefits for Medicare eligible expenses shall be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as are applicable to Medicare claims.

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Prior section 23.7 Loss Ratio Standards recodified to 23.8.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Standards for claims payment recodified from 23.7; requirements for compliance specified at (a)1 through 5.

#### 11:4-23.11 Loss ratio standards, annual filing of premium rates and refund or credit calculation

(a) For both the entire past and future periods for which revised or existing rates are computed to provide coverage, Medicare supplement policy forms or certificate forms shall be expected to return to policyholders and certificateholders, in the form of aggregate benefits under the policy or certificate calculated on the basis of paid claims experience (or paid health care expenses for coverage provided by a health maintenance organization on a service rather than reimbursement basis) and written premiums for such period, and with adjustment for interest to reflect the timing of payments:

1. At least 75 percent of the aggregate amount of premiums or subscription charges collected in the case of group policies and policies issued as conversions from group policies.

2. At least 65 percent of the aggregate amount of premiums or subscription charges collected in the case of individual policies.

(b) Each carrier shall include with the initial submission of rates for a new Medicare supplement policy an actuarial memorandum that includes the following:

1. The number of years for which the policy is expected to be delivered or issued for delivery in this State, and the number of policies expected to be delivered or issued for delivery for each form in each such year;

2. The anticipated loss ratio calculated over the life of the policy form, with separate disclosures of the present value of future paid benefits and the present value of future paid or written premiums utilized in the calculation of the anticipated loss ratio, where any statutorily required additional actuarial active life reserve is neither reflected in the future benefits nor the future premiums in the calculation;

3. The future benefits on both a paid and incurred basis and the future premiums on both a written and earned basis for each of the years recognized in the calculation of the anticipated loss ratio, where neither the future benefits nor the future premiums include, or are adjusted for, any statutorily required additional actuarial active life reserve;

4. The expected incurred/earned loss ratio for each of the years recognized in the calculation of the anticipated loss ratio, wherein:

i. The expected incurred claims shall equal expected paid claims adjusted for changes in the expected claim liabilities and claim reserves and in any expected statutorily required additional actuarial active life reserve for each such year; and

ii. The expected earned premiums shall equal premiums expected to be received adjusted for any changes in expected advance premiums and in expected unearned premium reserves for each such year, but changes in any expected statutorily required additional actuarial active life reserves shall not be included in the adjustment of premiums expected to be received;

5. The realistic assumptions used in the calculation of the loss ratios for each benefit provision wherein the premiums are determined separately including the following:

i. The annual claim costs (ultimate) by attained age and sex;

ii. The select and/or antiselect morbidity factors by policy duration (year) by issue age and sex;

iii. The lapse and mortality rates, or total termination rates, by policy duration by issue age and sex, and any skewing of those rates occurring within a policy year resulting from modal premium payments;

iv. The secular trend factors by policy duration by issue age and sex, which secular trend factors, when

used in the calculation of the anticipated loss ratio, shall not be applied for a period greater than the number of years for which trending is reflected in the calculation of premiums;

v. The interest rates by policy duration, which rates shall equal an insurer's recent, current and future expected new investment return rates (after investment expenses, but before Federal income taxes);

vi. Expenses by policy duration, including commission, override and bonus rates, other marketing expense rates, other maintenance expenses rates, any new-market expense rates, other acquisition expense rates, and the explicit profit margin or risk charge, provided on a per policy issue, per policy in force, per dollar of claim, per dollar of premium, and any other applicable bases;

vii. The distribution of expected policy issues by policy and rider benefits by issue age and sex;

viii. The percentage of policies expected to be issued with extra premiums for any physical, mental or medical conditions which result in substandard morbidity; and

ix. A summary statement of the underwriting standards (for example: short form medical and risk questionnaire, long form medical and risk questionnaire, medical examination), the marketing distribution system, and the market for the policy form (that is, the segment(s) of the general public to which the form will be marketed: middle income based on predetermined ZIP code selections for example);

6. A certification signed by an actuary, who must be a member of the American Academy of Actuaries, stating that the assumptions are appropriate to the policy form, reasonably represent the expected experience for the policy form and fully disclose the basis of the calculation of the anticipated loss ratio.

(c) Every carrier shall submit its rates annually for filing by the Commissioner. A filing for the revision of rates pursuant to (d) below shall satisfy this filing requirement. An annual rate filing shall specify an effective date for use of the rates, which date shall be after the date the filing is made but no later than six months following such date. The filing shall constitute compliance with the annual rate filing requirement for one year from the effective date for the use of the rates specified in the filing. Each subsequent annual rate filing shall specify an effective date for the use of the rates that is on or before one year from the effective date specified in the previous filing. Supporting documentation, as described below, shall be submitted with the annual rate filing. The supporting documentation shall use reasonable assumptions and shall demonstrate that the anticipated and aggregate loss ratios are at least as great as the originally anticipated loss ratio. The demonstration shall provide the following information and assumptions for each policy form used, and shall do so on a New Jersey basis and, if required by (g) below, on a national basis as well. Information on a national basis shall not be adjusted to reflect the difference, if any, between New Jersey rate levels and national rate levels.

1. For each prior calendar year, or portion of a prior calendar year, in which the policy form has been sold, the

carrier shall provide actual or estimated values of paid claims; paid or written premiums (specify which); incurred claims; earned premiums; and months exposed, and shall indicate whether the values provided are actual or estimated values. Estimated values may only be used for periods within three months of the date of the filing except for estimates of incurred claims and earned premiums. If the carrier uses duration-specific trend in projecting future claims or premiums, the data shall be subdivided by year of issue or duration. If the carrier does not use duration-specific trend in projecting future claims or premiums, the data may be subdivided by year of issue or duration at the option of the carrier.

2. For each future calendar year, or portion of a future calendar year, in which existing or newly issued policies of the policy form are expected to be in force in this State, provide the projected values of paid claims; paid or written premiums (specify); incurred claims; earned premiums; and months exposed using the assumptions specified at (c)5 below.

i. The numbers of years may be truncated if truncation will not impact compliance with loss ratio standards.

3. For each of the years or periods in (c)1 and 2 above, the carrier shall provide the paid/paid loss or paid/written loss ratio, and the incurred/earned loss ratio. Neither the future benefits nor the future premiums may include, or may be adjusted for, any statutorily required additional actuarial active life reserves.

4. The carrier shall provide the aggregate paid loss ratio calculated over the life of the policy form, and the anticipated loss ratio calculated over the future life of the policy form. The carrier shall indicate the following components of the calculation: accumulated value of past paid claims (with interest); sum of past paid claims (without interest); accumulated value of past paid or written premiums (with interest); sum of past paid or written premiums (without interest); present value of future paid claims (with interest); sum of future paid claims (without interest); present value of future paid or written premiums (with interest); and sum of future paid or written premiums (without interest).

5. The carrier shall use reasonable assumptions in calculating the anticipated loss ratio, and shall specify the components used, including:

i. Months exposed by year and, at the option of the carrier, duration (or year of issue);

ii. Paid claims per month exposed, including the impact, if any, of selection, duration (or year of issue), age and gender;

iii. Paid or written premium per month exposed, including the impact, if any, of selection, duration (or year of issue), age and gender;

iv. Total termination rates by duration (or year of issue), age and gender, including the impact of mode of premium payment, for the year for which the filing is effective;

v. New business to be issued, by age and gender, for the year for which the filing is effective;

vi. Trend factors in paid claims, by duration (or year of issue), age and gender, which trend factors shall only reflect the impact of aging and wear-off of selection after the year for which the filing is effective;

vii. A persistency assumption of 100 percent for years after the year for which the filing is effective, unless the carrier has withdrawn from the market pursuant to N.J.A.C. 11:4-23.13; and

viii. The interest rates to be used in accumulating or discounting paid premiums and claims, which rates shall equal the carrier's recent, current and future expected new investment return rates after investment expenses but before Federal income taxes.

6. The carrier shall submit the originally anticipated loss ratio for the form, the date of the initial rate filing, pursuant to (b) above, in which the originally anticipated loss ratio is given, the date of Department approval of the initial rate filing, and the effective date of the initial rate filing.

7. The carrier shall submit a certification signed by an actuary who is a member of the American Academy of Actuaries, stating that:

i. The assumptions used in the rate filing comply with this rule, are appropriate to the policy form, reasonably represent expected experience to the extent specified by this rule, and substantiate the calculation of the anticipated and aggregate loss ratios; and

ii. The anticipated and aggregate loss ratios, calculated according to the requirements of N.J.A.C. 11:4-23.11(c), exceed the originally anticipated loss ratio.

(d) Carriers shall submit revised rates for filing by the Commissioner. No carrier shall implement any rate revision until such rate revision has been filed. The same supporting documentation required by (c) above shall be submitted with the revised rates. Paid or written premiums and earned premiums as described by (c)2 above, and present value of future paid or written premiums and the sum of future paid or written premiums as described in (c)4 above shall be submitted both with, and without, the requested rate revision. The supporting documentation shall use reasonable assumptions. The supporting documentation shall demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage and the aggregate loss ratio are at least as great as the originally anticipated loss ratio. The demonstration shall provide the required information and assumptions for each policy form, and shall provide them on a New Jersey basis and, if required by (g) below, shall also provide them on a national basis. Premiums on a national basis shall not be adjusted to reflect the difference, if any, between New Jersey rate levels and national rate levels.

1. For policies issued prior to January 4, 1993, expected claims in relation to premiums shall meet:

i. The originally filed loss ratio when combined with the actual experience since inception;

ii. The appropriate loss ratio requirement from (a)1 and 2 above when combined with actual experience beginning with July 1, 1996 to date; and

iii. The appropriate loss ratio requirement from (a)1 and 2 above over the entire future period for which the rates are computed to provide coverage.

2. In meeting the tests in (d)1i, ii and iii above and for purposes of attaining credibility, an insurer may combine experience under policy forms which provide substantially similar coverage subject to the approval of the Commissioner. Once a combined form is adopted, the insurer may not separate the experience except with the approval of the Commissioner. The Commissioner shall permit pooling in plans having less than 10,000 employee/policyholder months on an annual basis.

3. Prior to the effective date of enhancements in Medicare benefits, carriers shall:

i. Submit for filing appropriate premium adjustments required to produce loss ratios commensurate with the loss ratios anticipated for the current premium for the applicable policies or certificates, with accompanying documentation sufficient to justify the adjustment, in the opinion of the Commissioner; and

ii. Make premium adjustments to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards of (a) above, and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the carrier for the policies and certificates. No premium adjustment which would modify the loss ratio experience under the policy, other than the adjustments described herein, shall be made at any time other than upon the policy renewal or anniversary date.

4. Every carrier shall submit for filing by the Commissioner a rate reduction whenever the expected aggregate loss ratio reported for a policy or certificate is less than the anticipated loss ratio for that policy or certificate, and the requirements of (c) above may not be met.

5. When a rate adjustment is requested pursuant to a change in the policy or certificate necessary to eliminate benefit duplication with Medicare, the submission for a rate change shall include any riders, endorsements, policy and certificate forms needed to accomplish the Medicare supplement coverage modification necessary to eliminate benefit duplications with Medicare. The forms shall result in a clear description of the Medicare supplement benefits provided by the policy.

6. If a carrier does not make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the appropriate loss ratio.

(e) Carriers shall submit for filing with the Commissioner annually on or before May 31 reports in accordance with the applicable reporting form contained in the Appendix to subchapters 16 and 23 of this chapter, Exhibit F, completed for each type in a standard Medicare supplement benefit plan.

1. If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), a refund or credit calculation shall be required.

i. The refund calculation shall be done on a State-wide basis for each type in a standard Medicare supplement benefit plan.

ii. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

iii. For purposes of this section, for policies or certificates issued prior to January 4, 1993, the carrier shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after May 31, 1996. The first report shall be due by May 31, 1998.

2. A refund or credit shall be made by carriers whenever the benchmark loss ratio exceeds the adjusted experience loss ratio, and the amount to be refunded or credited exceeds a de minimis level.

i. A refund or credit against premiums due shall be made no later than September 30 following the experience year upon which the refund or credit is based.

ii. The refunds and credits shall include interest accruing from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of the United States Department of Health and Human Services, which in no event shall be less than the average rate of interest for 13-week Treasury notes.

(f) The Commissioner may conduct a public hearing, in his or her discretion, to gather information regarding a request by a carrier for an increase in a rate for a policy or certificate form, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard of (a) above. The determination of compliance shall be made without consideration of any refund or credit for such reporting period. Public notices of the hearing shall be in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

(g) For purposes of complying with (c) and (d) above, premiums, claims, and months exposed shall refer to premiums and claims for insured residents of this State under a specific policy form. However, if the total past and future exposed months for the form is less than 12,000, the anticipated and aggregate loss ratios shall be calculated on both a national experience and State experience basis. A weighted average of loss ratios shall then be calculated for purposes of comparison to the originally anticipated loss ratio. The weighting factor "w" to be applied to the loss ratio based on State experience shall be the square root of the ratio of "a" (the total past and future exposed months) to 12,000, and the weighting factor applied to the national experience shall be 1-w.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section recodified from 23.7.

Added "and policies issued as conversions from group policies" in (a)1.

Substituted old text with new text in (b).

Added (b)1, 2; (c); (d); (e).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on required disclosure provisions recodified to 23.14; rule on loss ratio standards recodified from 23.8; standards for refunds and credit added.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.2004 d.246, effective July 6, 2004.

See: 35 N.J.R. 2562(a), 36 N.J.R. 3292(a).

Rewrote the section.

#### 11:4-23.12 Guaranteed issue for eligible persons

(a) Eligible persons are those individuals described in (c) below who seek to enroll under the policy during the period specified in (d) below, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

(b) With respect to eligible persons, a carrier shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in (f) below that is offered and is available for issuance to new enrollees by the carrier, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(c) An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

2. The individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates, the plan ceases to provide all health benefits to the individual or the individual leaves the plan;

3. The individual is enrolled with a Medicare + Choice organization under a Medicare + Choice Plan under Part C of Medicare, and any of the circumstances described in (c)3i through iv below apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare + Choice plan:

i. The organization's or plan's certification under Part C of Medicare has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

ii. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the Federal Social Security Act (42 U.S.C. § 1395w-21) (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856 (42 U.S.C. § 1395w-26)), or the plan is terminated for all individuals within a residence area;

iii. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(1) The organization offering the plan substantially violated a material provision of the organization's contract under Part C of Medicare in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(2) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

iv. The individual meets such other exceptional conditions as the Secretary may provide;

4. The individual is enrolled with any of the following, and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under (c)3 above:

i. An eligible organization under a contract under Section 1876 (42 U.S.C. § 1395mm) of the Social Security Act (Medicare cost);

ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

iii. An organization under an agreement under Section 1833(a)(1)(A) (42 U.S.C. § 1395) of the Social Security Act (health care prepayment plan); or

iv. An organization under a Medicare Select policy;

5. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because of the following:

i. Either the insolvency of the carrier or bankruptcy of the noncarrier organization, or other involuntary termination of coverage or enrollment under the policy;

ii. The carrier substantially violated a material provision of the policy; or

iii. The carrier, or an agent or other entity acting on the carrier's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

6. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare + Choice organization under a Medicare + Choice plan under Part C of Medicare, any eligible organization under a contract under Section 1876 (42 U.S.C. § 1395mm) of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act (42 U.S.C. § 1395eee), or a Medicare Select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) (42 U.S.C. § 1395w-2) of the Federal Social Security Act); or

7. The individual, upon first becoming eligible for benefits under Medicare Part A at age 65 or older, enrolls in a Medicare + Choice plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act (42 U.S.C. § 1395eee), and disenrolls from the plan by not later than 12 months after the effective date of enrollment.

(d) The guaranteed issue time periods shall be:

1. In the case of an individual described in (c)1 above, the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, in the absence of the receipt of such notice, the individual receives notice that a claim has been denied because of such a termination or cessation and ends 63 days after the date of the applicable notice; or

2. In the case of an individual described in (c)3, 4, 6 or 7 above whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of such termination and ends 63 days after the date the applicable coverage is terminated;

3. In the case of an individual described in (c)5i above, the guaranteed issue period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and the date that the applicable coverage is terminated. The guaranteed issue period ends on the date that is 63 days after the date the coverage is terminated;

4. In the case of an individual described in (c)3, 5ii or iii, or (c)6 or 7 above who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date; or

5. In the case of an individual described in (c) above but not described in the preceding paragraphs of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(e) The following shall apply to extended Medicare Supplement access for interrupted trial periods:

1. In the case of an individual described in (c)6 above (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in (c)6 above is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in (c)6 above;

2. In the case of an individual described in (c)7 above (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in (c)7 above is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in (c)7 above; and

3. For purposes of (c)6 and 7 above, no enrollment of an individual with an organization or provider described in (c)6 above, or with a plan or in a program described in (c)7 above, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(f) The Medicare supplement policy to which eligible persons are entitled under (c)1, 2, 3, 4 and 5 above is a Medicare supplement policy which has a benefit package classified as Plan A, B, C or F offered by any carrier. The Medicare supplement policy to which eligible persons are entitled under (c)6 above is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same carrier, or, if not so available, a policy described in the preceding sentence. The Medicare supplement policy to which eligible persons are

entitled under (c)7 above shall include any Medicare supplement policy offered by any carrier.

(g) At the time of an event described in (c) above because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy or plan, the organization that terminates the contract or agreement, the carrier terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of carriers issuing Medicare supplement policies under (a) and (b) above. Such notice shall be communicated contemporaneously with the notification of termination.

(h) At the time of an event described in (c) above because of which an individual ceases enrollment under a contract or agreement, policy or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the carrier offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of carriers issuing Medicare supplement policies under (a) and (b) above. Such notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

Emergency Rule, R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.12, Filing requirements for policies, certificates and premium rates, recodified to N.J.A.C. 11:4-23.13.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

Amended by R.2001 d.7, effective January 2, 2001.

See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

Amended by R.2003 d.220, effective May 19, 2003.

See: 35 N.J.R. 71(a), 35 N.J.R. 2184(a).

Rewrote the section.

#### **11:4-23.13 Filing requirements for policies, certificates and premium rates**

(a) No carrier shall deliver or issue for delivery in this State any Medicare supplement policy or certificate, any written application therefor, or any printed rider or endorsements to be applied thereto, unless the forms thereof have been submitted to and filed by the Commissioner.

1. At the expiration of 30 days after submission, the form shall be deemed filed unless affirmatively disapproved for filing by the Commissioner prior thereto.

2. If any such form is disapproved for filing by the Commissioner during the said 30-day period, it may not be delivered or issued for delivery unless and until such disapproval for filing is withdrawn. Such disapproval shall be subject to review 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.

3. The Commissioner may extend the 30-day period no more than another 30 days if written notice is provided to the insurer before the expiration of the initial 30 day period, in which event all but this paragraph shall apply to the extended period.

4. Forms filed by or deemed filed by the Commissioner may subsequently be withdrawn from filing. Insurers shall have the right to 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. An insurer may continue to deliver or issue for delivery such forms until a final decision in accordance with the withdrawal is rendered, following the request for a hearing, or, if no hearing is requested, delivery or issuance for delivery of such forms may continue no later than 30 days following notice of the withdrawal of that form.

(b) Disapproval for filing, or withdrawals of approval of the filing of any form, must be stated in writing with the grounds therefor included in the statement, in accordance with the rules of this State.

(c) No carrier shall use or revise premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been submitted to and filed by the Commissioner in accordance with (a) and (b) above. Pursuant to N.J.S.A. 17:29A-53, and in accordance with N.J.A.C. 11:1-45, notices of requests for prior approval rate increases shall be given to individual policyholders, and to group policyholders so as to enable them to notify certificateholders of the filing of the rate increase request.

(d) The Commissioner shall not file, and carriers shall not submit for filing, more than one Medicare supplement policy or certificate form of each type for each standard Medicare supplement benefit plan, except as the Commissioner may otherwise approve in accordance with (d)2 below.

1. For the purposes of this subchapter, "type" shall mean an individual policy, and a group policy, and at such time as a Medicare Select program shall become effective in this State, an individual Medicare Select policy, and a group Medicare Select policy.

2. The Commissioner may approve carriers, individually, to offer up to four additional policy or certificate forms of the same type for the same standard Medicare supplement benefit plan. Such forms shall be subject to the filing requirements of this section. The four additional policy or certificate forms of the same type shall be limited to one additional form of the same type for:

- i. The inclusion of Innovative Benefits;
- ii. The addition of either a direct response or an agent marketing method;

iii. The addition of either guaranteed issue or underwritten coverage; and

iv. The offering of Medicare supplement coverage to persons eligible for Medicare by reason of disability.

(e) A carrier shall not discontinue offering any policy or certificate form filed by the Commissioner on or after the effective date of this subchapter unless such form has been withdrawn from filing pursuant to (a)4 above, or the carrier provides notice of discontinuance of offer to the Commissioner at least 30 days prior to such discontinuance, in writing.

1. Discontinuance subject to notice to the Commissioner shall include the following:

i. Failure to actively offer for sale a policy or certificate form for more than 12 consecutive months;

ii. Sale or transfer of Medicare supplement policies or certificates to another carrier; and

iii. Revisions in the rating structure or methodology applicable to a Medicare supplement policy or certificate form which has not been otherwise submitted to and filed by the Commissioner in accordance with N.J.S.A. 11:4-23.11.

2. Carriers shall not submit for filing a new form for any Medicare supplement plan of the same type for which the carrier has discontinued issue of a policy or certificate for a period of five years following the notice of discontinuance to the Commissioner. The Commissioner may waive some or all of the five year period, in his or her discretion.

(f) Except for policies or certificates assumed under an assumption reinsurance agreement, the experience of all policy or certificate forms of the same type for a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation set forth at N.J.S.A. 11:4-23.11(d).

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Prior section 23.9, Requirements for replacement recodified to 23.12. Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on application forms and replacement coverage recodified to 3.15; rule on filing requirements recodified from 23.9; (c) through (f) added.

Recodified from N.J.A.C. 11:4-23.12 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.13, Compensation arrangements, recodified to N.J.A.C. 11:4-23.14.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

Amended by R.2004 d.344, effective September 20, 2004.

See: 36 N.J.R. 606(a), 36 N.J.R. 4317(a).

In (c), added the second sentence.

#### 11:4-23.14 Compensation arrangements

(a) No carrier or other entity shall provide to any producer a first year commission or first year compensation for the sale of Medicare supplement policies or certificates in an amount which exceeds 200 percent of the commission or compensation to be provided by that insurer or other entity for the selling or servicing of that policy or certificate in the second year or period of that policy or certificate.

(b) The commission or other compensation which may be provided in subsequent renewal years shall be, for no fewer than five renewal years, the same as that commission or compensation provided in the second year or period.

(c) No carrier or other entity shall provide compensation or commission to any producer, nor shall any producer receive commission or other compensation greater than the renewal commission or compensation payable by the replacing carrier on renewal policies or certificates when an existing policy or certificate is replaced.

(d) For purposes of this section, "compensation" means a pecuniary or nonpecuniary remuneration of any kind relating to the sale of a policy or certificate, including, but not limited to:

1. Bonuses;
2. Gifts;
3. Prizes;

4. Awards; and
5. Finders fees.

New Rule, R.1990 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Prior section 23.10, Severability recodified to 23.17.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on filing requirements for advertising recodified to 23.16; rule on compensation arrangements recodified from 23.10; compensation arrangement variables restricted further.

Recodified from N.J.A.C. 11:4-23.13 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.14, Required disclosure provisions, recodified to N.J.A.C. 11:4-23.15.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

### 11:4-23.15 Required disclosure provisions

(a) General rules concerning required disclosure provisions include the following:

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specification of such provision shall be consistent with the type of policy or certificate to be issued. Such provision shall appear on the first page of policies and certificates, and shall include any reservation by the carrier of a right to change premiums and any automatic renewal premium increases based on the policyholder's or certificateholder's age.

2. Except for riders or endorsements by which the carrier effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy or certificate, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits:
  - i. All riders or endorsements added after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage shall require signed acceptance by the insured;
  - ii. After the date of the policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium or subscription charges during the policy or certificate term, shall be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by the minimum standards of this State for Medicare supplement coverage, or if required by other law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth clearly.

3. A Medicare supplement policy or certificate shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitation shall appear as a separate paragraph in the policy or certificate and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium or subscription charge or fees refunded if, after examination of the policy or certificate, the insured is not satisfied for any reason.

6. Carriers issuing policies or certificates which provide hospital or medical expense coverage on an expense incurred, indemnity, or service benefit basis to persons eligible for Medicare shall provide to all applicants an informational brochure entitled "Guide to Health Insurance for People with Medicare", hereinafter referred to as "the Guide", in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration. The Guide is intended to improve the buyer's understanding of Medicare and ability to select the most appropriate coverage. Delivery of the Guide shall be made whether or not policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as set forth by this subchapter.

7. To ensure uniformity in content, form and printing, the Guide has been made available through the Publications Department of the National Association of Insurance Commissioners, Kansas City, MO.

8. Except in the case of direct response carriers, delivery of the Guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the Guide shall be obtained by the carrier. Direct response carriers shall deliver the Guide to the applicant upon request but in no instance shall delivery of the Guide occur later than the time of policy or certificate delivery.

9. Except as provided in (c) below, the terms "Medicare Supplement," "Medigap," and words of similar import shall not be used unless the policy or certificate is issued in compliance with N.J.S.A. 11:4-23.8 and all other sections of this subchapter.

(b) Outline of Coverage requirements for Medicare supplement policies and certificates include:

1. Carriers issuing Medicare supplement policies or certificates for delivery in this State shall provide an outline of coverage to all applicants at the time the application is presented to the prospective applicant. Except for direct response policies or certificates, acknowledgment of receipt of such outline shall be obtained by the carrier from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare Supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate actually issued must accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3. The outline of coverage provided to applicants pursuant to (b)1 above shall be in the language and format prescribed in Exhibit D of the Appendix to subchapters 16 and 23 of this chapter, incorporated herein by reference, in no less than 12 point type. The outline of coverage shall consist of a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the carrier. All plans A through J shall be shown on the cover page, and the plan(s) offered by the carrier shall be prominently identified. Premium information for the plan(s) offered by the carrier shall be provided on the cover page, or immediately following the coverage page, clearly and prominently, specifying both the premium and the mode. All possible premiums for the applicant on all plans offered to the applicant by the carrier shall be illustrated.

(c) All health and disability income policies, except as specified in this subsection, issued for delivery in this State to persons eligible for Medicare shall notify insureds under the policy. Such notice is not required for: Medicare supplement policies; policies of one or more employers or labor organizations, of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, of the labor organization; or policies issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.). The notice shall either be printed or attached to the first page of the outline of coverage delivered to the insureds under the policy, or, if no outline of coverage is delivered, to the first page of the certificate or policy delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language:

"THIS IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

1. Applications provided to persons eligible for Medicare for the health insurance policies described above shall disclose, using the applicable statement in Exhibit H in the Appendix the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as part of, or together with the application for the policy or certificate.

(d) At least 30 days prior to the effective dates of any Medicare benefit changes, notice shall be provided by carriers to New Jersey insureds describing the revisions of the Medicare program and the resulting modifications made by the carrier to an insured's Medicare supplement policy or certificate to eliminate duplication of Medicare benefits.

1. The notices shall be in the format set forth in the Appendix to subchapters 16 and 23 of this chapter, Exhibit C (Notice of Changes in Medicare and Your Medicare Supplement Coverage), which is incorporated herein as part of this rule.

2. No modification shall be made to an existing Medicare supplement policy or certificate when notices are sent except those modifications necessary to eliminate duplication of Medicare benefits.

3. Notices shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate.

4. Notices shall provide information as to when any premium adjustment is to be made due to changes in Medicare.

5. Information on benefit modifications and premium adjustments shall be in outline form and in clear and simple terms to facilitate comprehension.

6. Notices shall not contain or be accompanied by any solicitation.

7. No notice shall contain benefits and premium information for more than one policy or certificate form.

Amended by R.1987 d.95, effective February 2, 1987.

See: 18 N.J.R. 2103(a), 19 N.J.R. 291(a).

(a)6 substantially amended; (a)7 old text deleted and new text substituted.

Amended by R.1988 d.587, effective December 19, 1988 (operative January 1, 1989).

See: 20 N.J.R. 2510(a), 20 N.J.R. 3155(c).

Substantially amended.

Amended by R.1991 d.121, effective March 4, 1991.

See: 22 N.J.R. 771(a), 23 N.J.R. 690(c).

In (a)6 and 7iii: revised internal references; deleted (a)7iv, which was outdated text. In (a)7ii(3)-(4): revised required paper to be used.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section recodified from 23.8.

Deleted "or nonrenewal", "clearly state the duration, where limited, or renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. Such provision shall", "individual" in (a)1. Added (a)2.

Recodified existing (a)2 through 9 as 3 through 10.

Deleted "or hospital or medical service corporation.", "or subscriber", "all" in (a)3.

Designated 3i and ii; deleted "or subscriber".

Added "are required by the minimum standards for Medicare supplement insurance policies, or if" in (a)3ii.

Stylistic changes in (a)4, 5.

Deleted "other than those issued pursuant to direct response solicitation", "policyholder or certificate holder", "person or subscriber", "Medicare Supplement policies or certificates . . ."; added "insured", "or fees"; changed "10" days to "30" days in (a)6.

Deleted “and hospital and medical service corporations”, “or subscriber contracts”; added “Delivery of the informational brochure shall be made whether or not policies are advertised, solicited or issued as Medicare supplement policies as set forth by this subchapter.” in (a)7.

Changed “format” to “form” in (a)8.

Deleted “or service corporations” in (a)9. Added “and all other sections of this subchapter” in (a)10.

Deleted “or service organizations”; added “or certificates” in (b)1.

Added 5v. in Outline; deleted “N.J.A.C. 11:4-23.8(5)”; added “section 4” in 6 (outline).

Deleted “Any group”, “insurance policy or individual or group subscriber contract”, “subscriber contract”; added “All”, “and disability income policies”, “policy” in (c).

Added (d).

Substantial changes in format of the (b)3 outline as follows: Added “And Premium Information” to heading; added “Use this outline to compare benefits and premiums among policies”; added “and indexed copayments or deductibles, as appropriate” in (b)3 outline 4.

Changed “Service” to “Description”; deleted “Benefit” and “Medicare Pays” columns.

Added “I. Minimum Standards . . .”; deleted “Hospitalization” and “Post-Hospital Skilled Nursing Care”.

Added “II. Additional Benefits . . .”.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on requirements for marketing recodified to 23.17; rule on required disclosure provisions recodified from 23.11; Outline of Coverage deleted; individualized Medicare supplement plan charts added; new disclosures required.

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

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

Substantially amended (a)6 and 7.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Recodified from N.J.A.C. 11:4-23.14 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.15, Requirements for application forms and replacement coverage, recodified to N.J.A.C. 11:4-23.16.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

#### **11:4-23.16 Requirements for application forms and replacement coverage**

(a) Application forms shall include the following questions designed to elicit information as to whether a Medicare supplement policy or certificate is intended to be additional to any such policies or certificates. A supplementary application or other form to be signed by the applicant and agent may be used. In the case of a direct response carrier, a copy of the application or supplemental application, signed by the applicant and acknowledged by the carrier, shall be returned to the applicant by the carrier upon delivery of the policy or certificate. The application form or supplementary application form shall contain the questions and statements set forth below.

##### **1. Statements shall be as follows:**

i. You do not need more than one Medicare supplement policy.

ii. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.

iii. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

iv. The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

v. Counseling services may be available in your State to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the State Medicaid program including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

2. Questions, numbered 1, 2, 3 and 4, shall be as follows and shall be prefaced by the statement “To the best of your knowledge”:

i. Do you have another Medicare supplement policy or certificate in force? If so, do you intend to replace your current Medicare supplement policy with this policy (certificate)?

ii. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(1) If so, with which company?

(2) What kind of coverage?

iii. Are you covered for medical assistance through the State Medicaid program:

(1) As a Specified Low-Income Medicare Beneficiary (SLMB)?

(2) As a Qualified Medicare Beneficiary (QMB)?

(3) For other Medicaid medical benefits?

(b) Agents shall list any other health policies which they have sold to the applicant that are currently in force, and any such policies sold to the applicant within the previous five years that are no longer in force, clearly indicating which policies are in force and which are not.

(c) Upon determination that a sale will involve replacement of Medicare supplement coverage, a carrier or its agent shall furnish to the applicant, prior to the issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of such notice signed by the applicant and agent, except where coverage is sold without an agent, shall be provided to the applicant, and an additional signed copy shall be retained by the carrier. A direct response carrier shall deliver to the applicant at the time of the issuance of the policy (certificate) the notice regarding replacement of Medicare supplement coverage.

(d) Carriers shall include a waiver of all preexisting condition exclusion clauses, waiting periods, elimination periods or probationary periods in a replacement policy for at least that same period of duration of the conditional clause(s) in the applicant's existing policy which has expired at the time of issuance of the replacement policy, to the extent of the benefits of the existing policy.

(e) The notice required by (c) above shall be provided in substantially the form set forth in Exhibit E of the Appendix to Subchapters 16 and 23 of this chapter, incorporated herein by reference, in no less than 12 point type. Item (1) of the notice set forth in Exhibit E may be omitted or modified if preexisting conditions are covered under the new coverage. If the policy or certificate is guaranteed issue, item (3) of the notice of Exhibit E may be omitted.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section 23.9 "Requirements for replacement" recodified and reworded—"Requirements for application forms and replacement coverage".

Added "or certificate", "or Medicare supplement", "or is intended to be additional to any such policies or certificates", "and agent, except where coverage is not sold through an agent," "the questions shall be substantially as follows:" in (a). Added (a)1 through 4. Added (b), (d). Recodified existing (b) and (c) and (e) as (c), (e) and (f).

Deleted "or service corporation", "signed by the applicant", "certificate"; added "or certificate", "signed by the applicant and the agent, except where coverage is sold without an agent" in recodified (c).

Substantial revision of "Notice to applicant regarding Replacement of Accident and Sickness or Medicare Supplement Coverage" in recodified (e).

Deleted old (d).

Deleted "N.J.A.C. 11:4-23.9(c) and (d)"; added "(e)" and "or modified" in recodified (f).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on appropriateness of recommended purchase and excessive coverage recodified to 23.18; rule on requirements for application forms and replacement coverage recodified from 23.12; "Notice to Applicant . . ." deleted, with reference to Appendix E added; duplication of coverage and value to applicant to be included in application form.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Recodified from N.J.A.C. 11:4-23.15 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.16, Filing requirements for advertising, recodified to N.J.A.C. 11:4-23.17.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

#### 11:4-23.17 Filing requirements for advertising

(a) Every carrier providing Medicare supplement policies or certificates in this State shall file with the Commissioner a copy of all advertisements to which residents of this State will have access, and through which the carrier intends, or by implication purports to the reasonable targeted consumer its intent to make its Medicare supplement product(s) available for purchase or enrollment in this State, whether through written, radio, television or other electronic media, at least 30 days prior to the date on which the advertisement is to be used in this State, or made accessible to residents of this State.

(b) All advertisements shall be in accord with the standards set out in N.J.A.C. 11:2-11 and any other disclosure and advertising rules which may be applicable to carriers.

(c) The Commissioner may disapprove an advertisement at any time if the advertisement is not in compliance with this rule or is in violation of the Trade Practices Act, N.J.S.A. 17B:30-1 et seq. An advertisement which has been disapproved by the Commissioner shall continue to be disapproved until disapproval is withdrawn by the Commissioner.

(d) The Commissioner may institute any and all procedures and penalties available pursuant to N.J.S.A. 17:35C-1 et seq., 17B:26A-1 et seq., and 17B:30-1 et seq., against a carrier which is determined by the Commissioner to be in violation of this rule.

(e) All actions of the Commissioner are subject to review pursuant to the provisions of the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on reporting of multiple policies recodified to 23.19; rule on filing requirements for advertising recodified from 23.13; references to insurer changed to carrier.

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

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

Recodified from N.J.A.C. 11:4-23.16 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.17, Standards for marketing, recodified to N.J.A.C. 11:4-23.18.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

#### 11:4-23.18 Standards for marketing

(a) Every carrier, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

2. Establish marketing procedures to assure excessive coverage is not sold or issued to any consumer;

3. Display prominently by type, stamp or other appropriate means, on the first page of the policy or certificate the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

4. Make every reasonable effort to identify when a prospective applicant or enrollee already has Medicare supplement and/or accident and sickness coverage, the quantity of such policies and extensiveness of such coverage; and

5. Establish procedures which are auditable for purposes of verifying compliance with this section.

(b) Practices which are prohibited in this State, in addition to those set forth in N.J.S.A. 17B:30-1 et seq., include, but are not limited to, the following:

1. Twisting; that is, knowingly making any misleading representations or incomplete or fraudulent comparisons of any policies or carriers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convey any policy or certificate or to purchase any policy with another carrier;

2. High pressure tactics; that is, employing any method of marketing having the effect of or tending to induce the purchase or to recommend the purchase of coverage through force, fright, explicit or implied threat, or undue pressure; and

3. Cold lead advertising; that is, making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance or other similar coverage, and that further contact with the consumer will be made by an insurance agent, other producer or carrier.

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on severability recodified to 23.22; rule on standards for marketing recodified from 23.14; insurer changed to carrier.

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

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

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Recodified from N.J.A.C. 11:4-23.17 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.18, Appropriateness of recommended purchase and excessive coverage, recodified to N.J.A.C. 11:4-23.19.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

#### 11:4-23.19 Appropriateness of recommended purchase and excessive coverage

(a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of Medicare supplement coverage which will provide an individual with more than one Medicare supplement policy or certificate is prohibited.

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on appropriateness of recommended purchase and excessive coverage recodified from 23.15; exception at (b) deleted; prohibition of any sale which provides more than one coverage universal, without exception.

Recodified from N.J.A.C. 11:4-23.18 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.19, Reporting of multiple policies, recodified to N.J.A.C. 11:4-23.20.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

#### 11:4-23.20 Reporting of multiple policies

(a) Every carrier shall report annually, on or before March 1, to the Commissioner, the policy and certificate number and date of issuance of each policy or certificate, grouped by individual insureds for every individual resident of this State for which the carrier has in force more than one Medicare supplement policy or certificate.

(b) Carriers shall submit reports of multiple policies on a form substantially similar to that form set forth in Exhibit G of the Appendix to Subchapters 16 and 23 of this Chapter, incorporated herein by reference. Carriers shall submit separate forms for each insured for which multiple policies or certificates are being reported. No form shall contain information relevant to more than one insured. In any instance in which one form provides insufficient reporting space for an insured's policies or certificates, additional pages should be attached containing the additional information.

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on reporting of multiple policies recodified from 23.16, with reporting of multiple sales added; reference to Appendix E added. Recodified from N.J.A.C. 11:4-23.19 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.20, Addresses for submissions for filing, recodified to N.J.A.C. 11:4-23.21.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

#### 11:4-23.21 Addresses for submissions for filing

(a) All forms, rates, loss ratio reporting and advertisements submitted for filing with or by the Commissioner shall be submitted to the Division of Life and Health Actuarial Services, New Jersey Department of Insurance, PO Box 470, Trenton, New Jersey 08625-0470 directed to specific bureaus as follows:

1. Managed Care Bureau, for submissions from health maintenance organizations, dental plan organizations, and dental service corporations; and

2. Health Bureau, for submissions from insurers and health, hospital and medical service corporations.

(b) Annual reports of multiple policy issues submitted for filing with the Commissioner shall be submitted to the Division of Legislative and Regulatory Affairs, New Jersey Department of Insurance, PO Box 325, Trenton, New Jersey 08625-0325, to the attention of Medicare Supplement Multiple Policy Report.

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

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

Substantially amended (a).

Recodified from N.J.A.C. 11:4-23.20 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.21, Penalties, recodified to N.J.A.C. 11:4-23.22.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

#### 11:4-23.22 Penalties

Failure to comply with the terms of this subchapter may result in the assessment of any and all penalties available in accordance with the laws of this State.

Recodified from N.J.A.C. 11:4-23.21 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.22, Severability, recodified to N.J.A.C. 11:4-23.23.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

#### 11:4-23.23 Severability

If any provision of this subchapter or the application thereof to any person or circumstance is held to be invalid for any reason, the remainder of the subchapter and the application of such provision to other persons or circumstances shall not be affected thereby.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section recodified from 23.10.

Changed "rule" to "subchapter" with stylistic changes.

Recodified by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on severability recodified from 23.17, without change.

Recodified from N.J.A.C. 11:4-23.22 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

APPENDIX TO SUBCHAPTERS 16 AND 23

EXHIBITS A AND B (RESERVED)

EXHIBIT C  
(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE

THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

(A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.)

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In (Current Calendar Year) Medicare Pays Per Calendar Year	Effective January 1 (Coming Calendar Year) Medicare Will Pay	In (Current Calendar Year) Your Coverage Pays	Effective January 1 (Coming Calendar Year) Your Coverage Will Pay
<b>MEDICARE PART A</b>				
<b>SERVICES AND SUPPLIES</b>				
Inpatient Hospital Services	All but \$_____ for first 60 days/ benefit period	All but \$_____ for first 60 days/ benefit period		
Semi-Private Room and Board	All but \$_____ a day for 61st-90th days/benefit period	All but \$_____ a day for 61st-90th days/benefit period		
Misc. Hospital Services and Supplies, such as Drugs, X-Rays, Lab Tests and Operating Room	All but \$_____ a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)	All but \$_____ a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)		

BLOOD	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period
SKILLED NURSING FACILITY CARE	100% of costs for 1st 20 days (after a 3 day prior hospital confinement)/benefit period  All but \$_____ a day for 21st-100th days/benefit period  Beyond 100 days— Nothing/benefit period	100% of costs of 1st 20 days (after a 3 day prior hospital confinement) benefit period  All but \$_____ a day for 21st-100th days/benefit period  Beyond 100 days— Nothing/benefit period
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$_____ deductible); 50% for outpatient psychiatric services	80% of allowable charges (after \$_____ deductible/ calendar year); 50% for outpatient psychiatric services
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$_____ deductible/calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$_____ deductible/calendar year)
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after \$_____ deductible/calendar year)	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in (after \$_____ deductible/calendar year)

(Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.)

(Describe any coverage provisions due to Medicare modifications.)

(Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.)

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT (Policy) CONTACT:

(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT)

(ADDRESS/PHONE NUMBER)

EXHIBIT D  
PART ONE—COVER PAGE(S)  
(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE BENEFIT PLAN(S): (insert letter(s) of plan(s) being offered)

Medicare supplement insurance may be sold in only ten (10) standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your State.

**BASIC BENEFITS:** Included in ALL Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses.), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

Blood: First three (3) pints of blood each year.

<u>A</u> Basic Benefits	<u>B</u> Basic Benefits	<u>C</u> Basic Benefits	<u>D</u> Basic Benefits	<u>E</u> Basic Benefits	<u>F*</u> Basic Benefits	<u>G</u> Basic Benefits	<u>H</u> Basic Benefits	<u>I</u> Basic Benefits	<u>J*</u> Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Basic Drugs (\$3,000 Limit)
				Preventive Care					Preventive Care

\*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed the deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include, in plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible. The high deductible amount is adjusted annually.

PREMIUM INFORMATION (Boldface type)

We, (carriers name), may only raise your premium if we raise the premium for all policies like yours in this State. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change.)

PART TWO—DISCLOSURE PAGE(S)

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY  
(Boldface type)

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY (Boldface type)

If you find that you are not satisfied with your policy, you may return it to (Carrier's address). If you send the policy

back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT (Boldface type)

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE (Boldface type)

This policy may not fully cover all of your medical costs.

(for agents:)

Neither (Carrier's name) nor its agents are connected with Medicare.

(for direct response carriers:)

(Carrier's name) is not connected with Medicare.

This outline of coverage does not give all the details of Medicare. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

**COMPLETE ANSWERS ARE VERY IMPORTANT**  
(Boldface type)

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**PART THREE—PLAN CHARTS**

(Include for each plan prominently identified on the cover page, a chart illustrating the services, Medicare payments, plan payments and insured's payments for each plan using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. Include an explanation of any Innovative Benefits on the cover page and in the appropriate chart as specified below.)

**PLAN A  
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*Part A deductible amounts announced annually by HCFA.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [ ]**	\$0	[ ]** (Part A Deductible)
61st day through 90th day	All but [ ]** a day	[ ]** a day	\$0
91st day and after:			
-While using 60 lifetime reserve days	All but [ ]** a day	[ ]** a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100 days	All but [ ]** a day	\$0	Up to [ ]** a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A & B

<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN B**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*Part A deductible amounts announced annually by HCFA.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [ ]**	[ ]** (Part A Deductible)	\$0
61st day through 90th day	All but [ ]** a day	[ ]** a day	\$0
91st day and after:			
-While using 60 lifetime reserve days	All but [ ]** a day	[ ]** a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100 days	All but [ ]** a day	\$0	Up to [ ]** a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE

MEDICARE APPROVED SERVICES

-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*Part A deductible amounts announced annually by HCFA.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [ ]**	[ ]** (Part A Deductible)	\$0
61st day through 90th day	All but [ ]** a day	[ ]** a day	\$0
91st day and after:			
-While using 60 lifetime reserve days	All but [ ]** a day	[ ]** a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100 days	All but [ ]** a day	\$0	Up to [ ]** a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b>			
<b>MEDICARE APPROVED SERVICES</b>			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN D  
 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*Part A deductible amounts announced annually by HCFA.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [ ]**	[ ]** (Part A Deductible)	\$0
61st day through 90th day	All but [ ]** a day	[ ]** a day	\$0
91st day and after:			
-While using 60 lifetime reserve days	All but [ ]** a day	[ ]** a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100 days	All but [ ]** a day	Up to [ ]** a day	\$0 a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A & B

<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE**

Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan

-Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
-Calendar year maximum	\$0	\$1,600	

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0 benefit of \$50,000	80% to a lifetime maximum \$50,000 lifetime maximum	20% and amounts over the \$50,000 lifetime maximum

**PLAN E**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*Part A deductible amounts announced annually by HCFA.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [ ]**	[ ]** (Part A Deductible)	\$0
61st day through 90th day	All but [ ]** a day	[ ]** a day	\$0
91st day and after:			
-While using 60 lifetime reserve days	All but [ ]** a day	[ ]** a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100 days	All but [ ]** a day	\$0	Up to [ ]** a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

**MEDICARE (PART B)—MEDICAL SERVICES—PER BENEFIT PERIOD**

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Supplement Approved Amounts	Generally 80%	Generally 20%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Supplement Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—</b>			
BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE

MEDICARE APPROVED SERVICES

-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Charges	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
<b>****PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE</b>			
Some annual physical and preventive tests and services such as: digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All Costs

\*\*\*\*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F OR HIGH DEDUCTIBLE PLAN F  
 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses exceed the deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible. The high deductible amount is adjusted annually, and the current amount appears below.

\*\*\*Part A deductible amounts announced annually by HCFA.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [ ] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [ ] DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [ ]***	[ ]*** (Part A Deductible)	\$0
61st day through 90th day	All but [ ]*** a day	[ ]*** a day	\$0
91st day and after:			
-While using 60 lifetime reserve days	All but [ ]*** a day	[ ]*** a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100 days	All but [ ]*** a day	Up to [ ]*** a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

\*\*This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses exceed the deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible. The high deductible amount is adjusted annually, and the current amount appears below.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [ ] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [ ] DEDUCTIBLE,** YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—</b>			
BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE

MEDICARE APPROVED SERVICES

-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [ ] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [ ] DEDUCTIBLE,** YOU PAY
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$25 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN G**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*Part A deductible amounts announced annually by HCFA.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [ ]**	[ ]** (Part A Deductible)	\$0
61st day through 90th day	All but [ ]** a day	[ ]** a day	\$0
91st day and after:			
-While using 60 lifetime reserve days	All but [ ]** a day	[ ]** a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100 days	All but [ ]** a day	Up to [ ]** a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE

MEDICARE APPROVED SERVICES

-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE

Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan

-Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
-Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS

SERVICES

FOREIGN TRAVEL—NOT COVERED BY MEDICARE

Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA

First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN H  
 MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*Part A deductible amounts announced annually by HCFA.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [ ]**	[ ]** (Part A Deductible)	\$0
61st day through 90th day	All but [ ]** a day	[ ]** a day	\$0
91st day and after:			
-While using 60 lifetime reserve days	All but [ ]** a day	[ ]** a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100 days	All but [ ]** a day	Up to [ ]** a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE

MEDICARE APPROVED SERVICES

-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
<b>BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE</b>			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%—\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN I

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*Part A deductible amounts announced annually by HCFA.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [ ]**	[ ]** (Part A Deductible)	\$0
61st day through 90th day	All but [ ]** a day	[ ]** a day	\$0
91st day and after:			
-While using 60 lifetime reserve days	All but [ ]** a day	[ ]** a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100 days	All but [ ]** a day	Up to [ ]** a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—FOR DIAGNOSTIC SERVICES</b>			
	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE

MEDICARE APPROVED SERVICES

-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE

Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan

-Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
-Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
<b>BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE</b>			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%—\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

**PLAN J OR HIGH DEDUCTIBLE PLAN J  
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year deductible. Benefits from the higher deductible plan J will not begin until out-of-pocket expenses exceed the deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible. The high deductible amount is adjusted annually, and the current amount appears below.

\*\*\*Part A deductible amounts announced annually by HCFA.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [ ] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [ ] DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [ ]***	[ ]*** (Part A Deductible)	\$0
61st day through 90th day	All but [ ]*** a day	[ ]*** a day	\$0
91st day and after:			
-While using 60 lifetime reserve days	All but [ ]*** a day	[ ]*** a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
-Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100 days	All but [ ]*** a day	Up to [ ]*** a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

\*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

\*\*This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses exceed the deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible. The high deductible amount is adjusted annually, and the current amount appears below.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [ ] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [ ] DEDUCTIBLE,** YOU PAY
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES—</b>			
BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE

MEDICARE APPROVED SERVICES

-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE

Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
-Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
-Number of visits covered (must be 8 weeks of last Medicare-Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
-Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS

SERVICES	MEDICARE PAYS	AFTER YOU PAY [ ] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [ ] DEDUCTIBLE,** YOU PAY
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit	20% and amounts over the \$50,000 lifetime maximum
<b>EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE</b>			
First \$250 each calendar year	\$0	\$0	\$250
Next \$6,000 each calendar year	\$0	50%—\$3,000 calendar year maximum benefit	50%
Over \$6,000 each calendar year	\$0	\$0	All Costs
<b>**** PREVENTIVE MEDICARE CARE BENEFIT—NOT COVERED BY MEDICARE</b>			
Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All Costs

(INNOVATIVE BENEFIT)

SERVICES	MEDICARE PAYS	AFTER YOU PAY [ ] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [ ] DEDUCTIBLE,** YOU PAY
(Description of benefits) (Description of conditions, limitations, exclusions, including any applicable deductible and coinsurance requirements)	(Per day or per benefit period, as applicable)	(Per day or per benefit period, as applicable)	(Per day or per benefit period, as applicable)

\*\*\*\*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

EXHIBIT E  
NOTICE TO APPLICANT REGARDING  
REPLACEMENT OF MEDICARE  
SUPPLEMENT COVERAGE  
(Carrier's Name and Address)

SAVE THIS NOTICE!

IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement coverage and replace it with coverage issued by (Carrier's Name). Your new (policy) (certificate) (coverage) provides thirty (30) days within which you may decide without cost whether you desire to keep the coverage.

You should review this new coverage carefully. Compare it with all accident and sickness and other health coverage you may have. If, after due consideration, you find that purchase of this coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY CARRIER, AGENT (BROKER OR OTHER REPRESENTATIVE):

I (We) have reviewed your current medical or health coverage. To the best of my (our) knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare Supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits
No change in benefits, but lower premiums
Fewer benefits and lower premiums
Other (please specify):

(1) Health conditions which you presently may have (preexisting conditions) may not be immediately or fully covered under the new (policy) (certificate) (coverage). This could result in denial or delay of a claim for benefits under the new (policy) (certificate) (coverage) whereas a similar claim may be payable under your present coverage.

(2) State law provides that your replacement (policy) (certificate) (coverage) may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods in the new (policy) (certificate) (coverage) for similar benefits to the extent such time had partially or fully expired under the original policy.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to answer truthfully and completely all questions on the application concerning your medical and health history. Failure to include all material medical information on the application may provide a basis for (Carrier's Name) to deny any future claims and to refund your payments as though your (policy) (certificate) (coverage) had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

(4) Do not cancel your present (policy) (contract) (coverage) until you have received your new (policy) (contract) (coverage) and are sure that you want to keep it.

Signature of Agent, Broker or Other Representative

(Direct response carriers may omit this signature line.)

Typed Name and Address of Agent, Broker or Other Representative

(Direct response carriers may omit this signature line.)

The above "Notice to Applicant" was delivered to me on:

Date \_\_\_\_\_

Applicant's signature \_\_\_\_\_

Carrier's Name \_\_\_\_\_

EXHIBIT F

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE \_\_\_\_\_ SMSBP (w) \_\_\_\_\_

For the State of \_\_\_\_\_

Company Name \_\_\_\_\_

NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_

Person Completing This Exhibit

Title \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

(a)	(b)
Earned	Incurred
Premium (x)	Claims (y)

Line

1. Current Year's Experience
  - a. Total (all policy years)
  - b. Current Year's issues (z)
  - c. Net (for reporting purpose = 1a - 1b)
2. Past Year's Experience (All Policy Years)
3. Total Experience (Net Current Year + Past Years' Experience)
4. Refunds last year (Excluding Interest)
5. Previous Since Inception (Excluding Interest)
6. Refunds Since Inception (Excluding Interest)
7. Benchmark Ratio Since Inception  
(SEE WORKSHEET FOR RATIO 1)
8. Experienced Ratio Since Inception  

$$\frac{\text{Total Actual Incurred Claim (line 3, col. b)}}{\text{Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)}} = \text{Ratio 2}$$
9. Life Years Exposed Since Inception \_\_\_\_\_  
 If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.
10. Tolerance Permitted (obtained from credibility table) \_\_\_\_\_
11. Adjustment to Incurred Claims for Credibility  

$$\text{Ratio 3} = \text{Ratio 2} + \text{Tolerance}$$
 If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.  
 If Ratio 3 is less than benchmark ratio, then proceed.

12. Adjusted Incurred Claims =

(Total Earned Premiums (line 3, col. a)—Refunds Since Inception (line 6)) × Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col. a)—Refunds Since Inception (line 6) - (Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1))

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000+	0.0%
5,000-9,000	5.0%
2,500-4,999	7.5%
1,000-2,499	10.0%
500-999	15.0%

If less than 500, no credibility.

- (v) Individual, Group, Individual Medicare Select or Group Medicare Select Only.
- (w) "SMSBP" = Standardized Medicare Supplement Benefit Plan. - use "p" for pre-standardized plans.
- (x) Includes model loadings and fees charged.
- (y) Excludes Active Life Reserves
- (z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature \_\_\_\_\_

Name—Please Type \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Reporting Form for the Calculation of Benchmark Ratio Since Inception for Individual Policies for Calendar Year \_\_\_\_\_

TYPE \_\_\_\_\_ SMSBP (p) \_\_\_\_\_  
 FOR THE STATE OF \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_  
 Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss ratio	(j) (h)x(i)	(o) Policy Year Loss ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(l):		(m):		(n):		

- Benchmark Ratio Since Inception = (l + n) / (k + m)
- (a): Year 1 is the current calendar year minus 1; Year 2 is the current calendar year minus 2; ... etc. ... (Example: If current year is 1991, then Year 1 is 1990; Year 2 is 1989; etc.)
  - (b): For calendar year(s) in column (a), the premium earned during each year for policies issued in each specific year.
  - (o): These loss ratios are not explicitly used in computing the benchmark loss ratios, but are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown for informational purposes only.
  - (p): "SMSBP" means Standardized Medicare Supplement Benefit Plan.

Reporting Form for the Calculation of Benchmark Ratio Since Inception for Group Policies for Calendar Year \_\_\_\_\_

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 FOR THE STATE OF \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_  
 Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

(a) <sup>3</sup> Year	(b) <sup>4</sup> Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss ratio	(j) (h)x(i)	(o) <sup>5</sup> Policy Year Loss ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception = (l + n) / (k + m)

- Individual, Group, Individual Medicare Select or Group Medicare Select Only.
- "SMSBP" means Standardized Medicare Supplement Benefit Plan. Use "p" for pre-standardized plans.
- Year 1 is the current calendar year minus 1; Year 2 is the current calendar year minus 2; ... etc. ... (Example: If current year is 1991, then Year 1 is 1990; Year 2 is 1989; etc.)
- For calendar year(s) in column (a), the premium earned during each year for policies issued in each specific year.
- These loss ratios are not explicitly used in computing the benchmark loss ratios, but are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown for informational purposes only.

EXHIBIT G  
 FORM FOR REPORTING MULTIPLE MEDICARE SUPPLEMENT POLICIES

Company Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

Signature \_\_\_\_\_

Name and Title (please type) \_\_\_\_\_

Date \_\_\_\_\_

EXHIBIT H  
DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for  
Health Insurance Policies Sold to Medicare  
Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the Federal Social Security Act prohibits the sale of a health insurance policy (the term policy or policies includes certificates) that duplicates Medicare benefits unless it will pay benefits without regard to other health coverage and it includes the prescribed disclosure statement on or together with the application.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text.)
3. State and Federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The Federal law does not pre-empt state laws that are more stringent than the Federal requirements.
8. The Federal law does not pre-empt existing state form filing requirements.
9. Section 1882 of the Federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Exhibit H remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statement or the alternative disclosure statements and not use both simultaneously.

(Original disclosure statement for policies that provide benefits for specified limited services).

IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME  
MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Original disclosure statement for policies that provide benefits for both expenses incurred and fixed indemnity basis)

IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME  
MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

#### Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies)

#### IMPORTANT NOTICE TO PERSONS ON MEDICARE

##### THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

##### This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

#### Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only)

#### IMPORTANT NOTICE TO PERSONS ON MEDICARE

##### THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

##### This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

#### Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Original disclosure statement for other health insurance policies not specifically identified in the previous statements.)

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME  
MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

**Before You Buy This Insurance**

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Alternative disclosure statement for policies that provide benefits for specified limited services.)

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT  
INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization

- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Alternative disclosure statement for policies that provide benefits upon both an expenses-incurred and fixed indemnity basis.)

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT  
INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.)

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**

**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling service.

(Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.)

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**

**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare generally pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling service.

(Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.)

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**

**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

#### Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Amended by R.1991 d.121, effective March 4, 1992.  
See: 22 N.J.R. 771(a), 23 N.J.R. 690(e).

Amended Appendix text throughout in order to update and clarify changes in Medicare and secondary insurance coverage. Reorganized appendix into Exhibits A through C, with Exhibit C adding new text. Deleted information insert, "Information Concerning Changes to the Medicare Program Effective January 1, 1989," because it is obsolete. Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

APPENDIX substantially revised.

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

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

Exhibits A and B, repealed.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.1999 d.161, effective May 17, 1999.

See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

### SUBCHAPTER 23A. MEDICARE SUPPLEMENT— UNDER 50 COVERAGE

#### 11:4-23A.1 Purpose and scope

(a) The purpose of this subchapter is to establish a mechanism to provide Plan C coverage of the standardized Medicare supplement plans to persons under 50 years of age residing in this State who are enrolled in Medicare due to disability, or due to end stage renal disease.

(b) Except when inconsistent with a provision of this subchapter, the provisions of N.J.A.C. 11:4-23 shall apply.

Amended by R.1997 d.61, effective February 3, 1997.

See: 28 N.J.R. 4705(b), 29 N.J.R. 446(a).

At the end of (a), deleted “, until they reach the age of 65”.

#### 11:4-23A.2 Definitions

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

“Applicant” means an individual who, at the time of application to the Under 50 Plan, has not attained the age of 50 years. In the event that an applicant for Under 50 Plan coverage is disqualified solely because of age, the date of application to the Under 50 Plan shall be deemed to apply to any application for coverage pursuant to N.J.A.C. 11:4-23B.

“Commissioner” means the Commissioner of the Department of Banking and Insurance.

“Continuous period of creditable coverage” means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

“Contracting carrier” means an insurer selected and appointed to service the Under 50 Plan in accordance with its plan of operation.

“Creditable coverage” means coverage of the individual, other than coverage of excepted benefits, provided under any of the following: a group health plan; health insurance coverage; Title XIX of the Social Security Act (Medicaid), other than the coverage consisting solely of benefits under section 1928 (42 U.S.C. § 1396s); Chapter 55 of Title 10 United States Code (CHAMPUS) (10 U.S.C. §§ 1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a State health benefits risk pool; a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program) (5 U.S.C. §§ 8901 et seq.); a public health benefit plan as defined in 45 C.F.R. 146.113(a)(1)(ix); and a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)).

6. All communications between either the assuming or ceding insurer with the policyholders, including letters, memoranda, identification cards, advertisements or other material;

7. Affirmative consent of the owner is not required, but if obtained, the consent form shall be part of the submission. The certificate of assumption form shall not include a provision indicating that consent of the policyholder is deemed or implied as the result of some positive or negative action;

8. A certification by the assuming insurer that it will adhere to all conditions and representations which were part of the original filing of the forms being assumed;

9. Certifications by the assuming and ceding insurers that any communications by a policyholder with the ceding insurer will have the same legal status as a communication which is sent directly to the assuming insurer. Additionally, the ceding insurer shall certify that it will maintain systems to forward all communications of this nature to the assuming insurer;

10. The certificate of assumption form shall include the following:

- i. An appropriate title, such as Certificate of Assumption;
- ii. The business address of both the ceding and assuming insurers;
- iii. Clear directions regarding the submission of payments and claims; and
- iv. The signature of an officer of the insurer, and a statement that the form is to be attached to and made part of the policy; and

11. If health insurance or credit insurance is being assumed, the assuming insurer shall agree that rate revisions will be based on the experience since the original issue date. It is the responsibility of the assuming insurer to obtain and maintain the necessary experience data.

#### 11:4-40.9 File and use eligibility

(a) An insurer may deliver or issue for delivery in this State a form providing life, health or annuity benefits, and accompanying rates if applicable, without obtaining prior approval from the Commissioner pursuant to this subchapter provided the form is set forth in this section as a type eligible for file and use and is filed with the Commissioner pursuant to the procedures set forth at N.J.A.C. 11:4-40.10, or the form is specifically exempt from compliance with this subchapter.

(b) The following types of non-variable individual life insurance forms shall be eligible for file and use pursuant to this section:

1. Scheduled premium term policies without cash values, other than universal/flexible-factor forms, multiple-

life forms with survivorship benefits, limited death benefit forms, policies with re-entry options, single premium forms, field issued forms or funeral insurance;

2. Accidental death benefit;
3. Business exchange/substitute insured;
4. Cost of living benefit;
5. Option to purchase additional insurance;
6. Waiver of premium;
7. Spouse and/or child rider; and
8. Applications.

(c) The following types of non-variable individual annuity forms shall be eligible for file and use pursuant to this section:

1. Immediate annuities, other than structured settlement, field issued forms or funeral insurance;
2. Scheduled premium deferred annuities, other than structured settlement, field issued forms or funeral insurance;
3. Flexible premium deferred annuities, other than structured settlement, field issued forms or funeral insurance;
4. Waiver of premium; and
5. Applications.

(d) The following types of individual health insurance forms shall be eligible for file and use pursuant to this section:

1. Business buyout, keyperson and overhead expense disability income policies;
2. Medical expense conversion policies in which a portion of the premium is chargeable to or subsidized by the group policy from which conversion is made;
3. Benefit riders for use with the type of policies set forth at (d)1 and 2 above; and
4. Applications other than those used with medicare supplement and long-term care policies.

(e) The following types of non-variable group life insurance forms shall be eligible for file and use pursuant to this section:

1. Policies and certificate forms which provide life insurance benefits only, and which do not provide cash values or loan values other than funeral expense;
2. Retired lives reserve contracts;
3. Benefit riders for use with the type of policies set forth at (e)1 and 2 above; and
4. Applications and evidence of coverage forms.

(f) The following types of group health insurance forms shall be eligible for file and use pursuant to this section:

1. Policies, certificates and evidence of coverage which provide only temporary disability benefits pursuant to N.J.S.A. 34:15-1 et seq.;
2. Policies and certificates which provide only disability income benefits for loss due to both accident and sickness and which are sold exclusively to employer groups;
3. Benefit riders for use with the type of policies set forth at (f)1 and 2 above; and
4. Applications and evidence of coverage forms.

(g) In the month of September or October of each year, the Department shall conduct a hearing pursuant to P.L. 1995, c.73 for the purpose of determining the specific types of forms eligible for file and use pursuant to this section.

1. The hearing shall be preceded by a notice of hearing published in the New Jersey Register at least 30 days prior to the date of the hearing, which notice shall include information concerning the date by which, and the person to whom, written public comment may be made. Notice shall also be provided to persons who have previously requested receipt of such notice.

2. The notice published in the New Jersey Register and as otherwise provided pursuant to (g)1 above shall also request that persons who wish to testify at the hearing provide the Department with timely notice of this intention, including a brief summary of the subject matter of their testimony.

3. The notice shall indicate whether the hearing shall address the merits of maintaining all forms currently on the file and use eligibility list, or whether the hearing will consider only specific additions, deletions or clarifications regarding the list.

4. The hearing shall be conducted by a hearing officer designated by the Commissioner. The length of testimony permitted at the hearing and the receipt of questions from the floor will be within the discretion of the hearing officer.

5. A transcript of the hearing shall be made and a copy thereof shall be made available to any interested person upon request and payment of the appropriate fee.

6. The record of the hearing shall include the following:

- i. Timely-received written public comments;
- ii. The transcript of the hearing; and
- iii. Any other information which the hearing officer may deem relevant.

7. The record and transcript of the hearing shall be public records pursuant to N.J.S.A. 47:1A-1 et seq. except to the extent that any information is submitted pursuant to a statute or rule providing for confidentiality.

8. Upon review of the file and use eligibility list hearing record, the Commissioner shall determine within 30 days whether any modifications should be made by rule to the current list.

9. If the Commissioner determines during the term of a duly promulgated file and use eligibility list that changed conditions require a modification of the list, the Commissioner may amend the list by rule following a hearing conducted pursuant to this subsection.

Public Notice: Hearing to determine forms eligible for filing and use.  
See: 28 N.J.R. 4121(a).

Public Notice: Hearing to determine forms eligible for filing and use.  
See: 30 N.J.R. 3108(b).

Public Notice: Hearing to determine forms eligible for filing and use.  
See: 33 N.J.R. 3379(a).

Amended by R.2001 d.408, effective November 5, 2001.  
See: 33 N.J.R. 2263(a), 33 N.J.R. 3747(a).

In (a), added “, or the form is specifically exempt from compliance with this subchapter”; deleted former (g); recodified former (h) as (g) and substituted “(g)1” for “(h)1”.

Public Notice: Notice of Public Hearing; Life/Health/Annuity Forms Certification Eligibility.

See: 34 N.J.R. 3544(b).

Public Notice: Life/Health/Annuity Forms certification eligibility.

See: 35 N.J.R. 4144(a).

Amended by R.2004 d.174, effective May 3, 2004.

See: 35 N.J.R. 4437(a), 36 N.J.R. 2197(a).

In (b), deleted former 8 and recodified former 9 as 8; in (c), deleted former 4 and recodified former 5 and 6 as 4 and 5.

Public Notice: Life/Health/Annuity Forms Certification Eligibility.

See: 36 N.J.R. 3940(a).

#### 11:4-40.10 File and use procedures

(a) An insurer seeking to file and use a form specified at N.J.A.C. 11:4-40.9 to be eligible for file and use shall, in addition to the items set forth at N.J.A.C. 11:4-40.5(b), submit the following to the Department:

1. A certification memorandum signed and acknowledged by a responsible officer of the insurer, which shall include the following:

i. A statement that the certification is filed pursuant to P.L. 1995, c.73, section 17;

ii. A statement that the responsible officer signing the certification memorandum is authorized to execute the document;

iii. A statement that the responsible officer signing the certification memorandum is familiar with the insurer's filing and all laws, regulations, bulletins and published guidelines applicable to the particular type of form, and that the form complies with all laws, regulations, bulletins and published guidelines applicable to the particular type of form;