

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. Reinstitution 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.

#### 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 determina-

tion 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;

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.

#### 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;

iv. A statement that the insurer intends for the Department to rely on the certification in accepting the filing made pursuant to this subsection;

v. A statement that the responsible officer signing the certification memorandum is aware of the penalties for submitting an improper certification or false filing;

vi. A statement that the responsible officer signing the certification memorandum has supervised and is responsible for the completion and submission to the Department of the checklist required for the particular type of form; and

vii. A statement that the insurer shall not use the form before receipt of the form is acknowledged by the Department.

(b) The Department shall provide the insurer with a written acknowledgement that the Department received the form and a proper certification.

(c) Upon receipt of the written acknowledgment described in (b) above, the insurer may use the form in this State.

(d) If the Commissioner determines that the form submitted to the Department by the insurer pursuant to (a) above fails to comply with any law, or regulation, bulletin or published guideline applicable to the particular type of form, the Department shall notify the insurer in writing of the specific reasons for objecting to the form, and may disapprove the form for further use in this State.

(e) If the Commissioner determines that the certification submitted to the Department by the insurer pursuant to (a) above is an improper certification, the insurer shall be subject to the following penalties specifically determined by the Commissioner in consideration of the severity of the

violation based on the potential adverse impact to the public and whether it is the insurer's first such violation:

1. A fine not to exceed \$50,000; and

2. A maximum penalty of \$1,000 per contract or certificate issued with a form determined to be improperly certified pursuant to this subsection.

i. For purposes of this subsection, an "improper certification" means a certification that provides any misrepresentation or false statement material to a certification form.

(f) If, following notice and a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 17:27, an insurer is found by the Commissioner to be in violation of any of the requirements of this section, the form may be disapproved and the insurer may be barred from participating in the certification process pursuant to this section for a period not to exceed one year. These penalties are in addition to any penalties that may be imposed pursuant to any other law or regulation applicable to the particular insurer for such violation(s).

#### **11:4-40.11 Service fees**

A form submitted by an insurer to the Commissioner for either prior approval or file and use pursuant to this subchapter shall be accompanied by the service fee(s) set forth at N.J.A.C. 11:1-32 unless the insurer is exempt from the payment of such fees pursuant to section 13 of P.L. 1995, c.156, enacted on June 30, 1995.

APPENDIX

EXHIBIT A

FOR DEPARTMENT OF INSURANCE  
USE ONLY, DO NOT USE SHADED AREAS

PAGE:  OF

NEW JERSEY  
DEPARTMENT OF INSURANCE  
POLICYFORM REVIEW

**\*\* NEW SUBMISSION \*\***

SUBMISSION NO.:  -  -

NAIC CODE:

COMPANY NAME:

GROUP CODE (if any):

DATE SENT:  /  /

DATE RECEIVED:  /  /

SERVICE FEE submitted:  .  (if applicable)

CHECK NUMBER:

CHECK DATE:  /  /

CATEGORY OF FORMS:

NUMBER OF FORMS SUBMITTED:

POLICYFORM NUMBER	COVER. TYPE	FORM TYPE	REQ. TYPE	RATE CHANGE (%)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> . <input type="text"/>

ATTACHMENT 1  
INSTRUCTIONS FOR INITIAL SUBMISSION  
DATA FORMS

Submission No:  
Leave Blank-For Department Use.

NAIC Code:  
5 Digit NAIC Code. All companies are identified in the system by NAIC code rather than name.