

CHAPTER 4

ACTUARIAL SERVICES

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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SUBCHAPTER 1. (RESERVED)

SUBCHAPTER 2. REPLACEMENT OF LIFE
INSURANCE POLICY

11:4-2.1 Purpose

(a) The purpose of this subchapter is:

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

11:4-2.2 Definitions

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

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

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

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

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

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

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

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

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

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

11:4-2.3 Exemptions

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

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

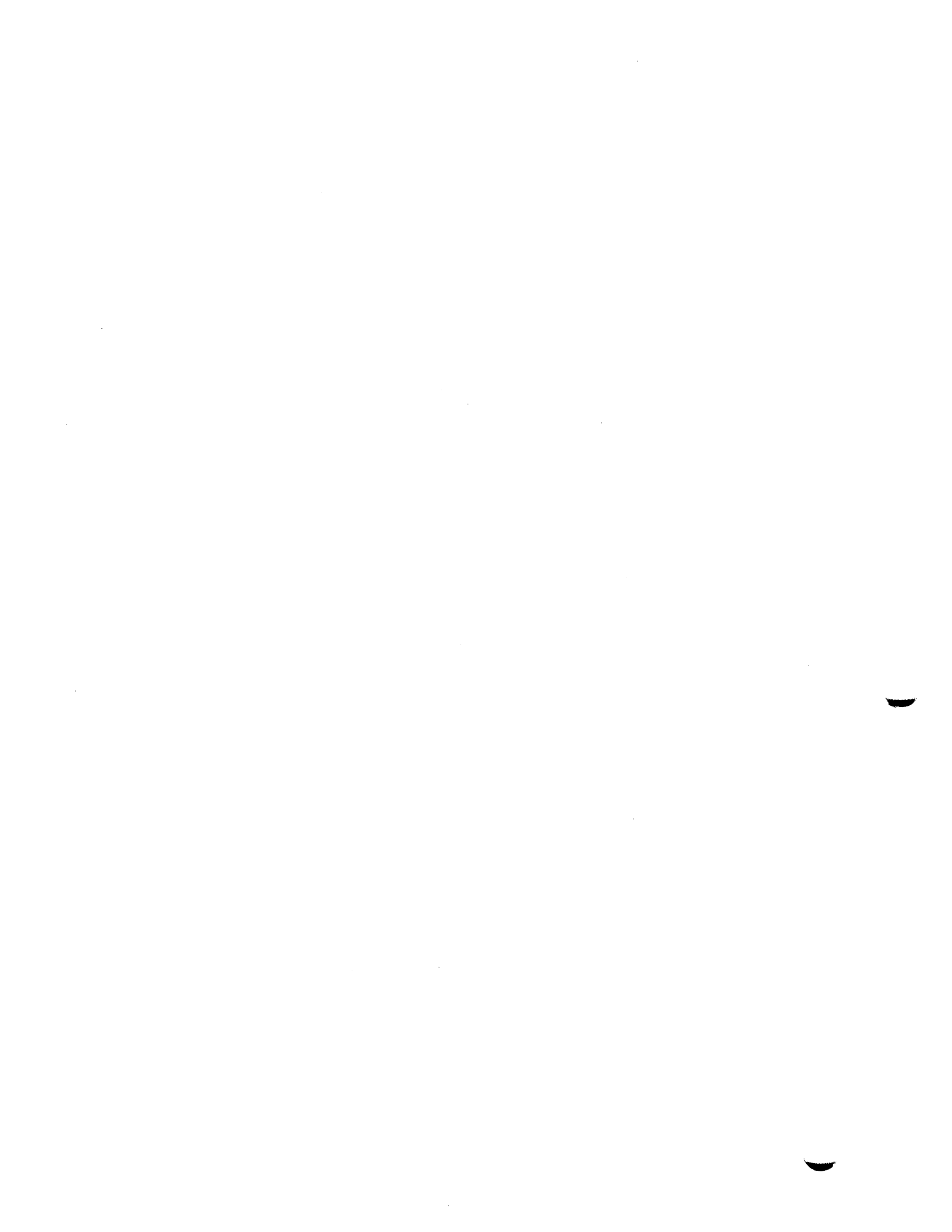
6. Existing life insurance that is a non-convertible term life insurance policy which will expire in five years or less and cannot be renewed; or

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

11:4-2.4 Duties of agent

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

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



2. Payment for all or a portion of the expenses incurred;
3. A combination of 1 and 2 above; or
4. An indemnification.

“Claim determination period” means the period of time, which shall not be less than 12 consecutive months, over which allowable expenses are compared with total benefits payable in the absence of COB, to determine whether benefit duplication exists and how much each plan will pay or provide.

1. The claim determination period shall generally be a calendar year, but a plan may use some other period of time that fits the coverage of the plan. A person may be covered by a plan during a portion of a claim determination period if that person’s coverage starts or ends during the claim determination period.

2. As each claim is submitted, each plan shall determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. This determination shall be subject to adjustment as later allowable expenses are incurred in the same claim determination period.

“COB” means coordination of benefits.

“Group type coverage” means coverage which is not available to the general public and which can be obtained and maintained only because of membership in, or connection with, a particular organization or group.

“Plan” means coverage with which coordination is allowed. The definition of “plan” in the group contract must state the coverages which will be considered in applying the COB provision of that contract. The right to include a coverage shall be limited by 1 through 3 below.

1. Any definition that satisfies the substance of this definition at N.J.A.C. 11:4-28.2 may be used. The definition of “plan” shown in the Model COB Provision in Appendix A of this subchapter is an example of what may be used.

2. This subchapter uses the term “plan”. However, a group contract may, instead, use “program” or a comparable term.

3. A “plan” may include:
 - i. Group insurance and group subscriber contracts;
 - ii. Uninsured arrangements of group or group-type coverage;
 - iii. Group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans;
 - iv. Group hospital indemnity benefit amounts exceeding \$150.00 per day; and

- v. Medicare or other governmental benefits, except those benefits as provided in 4vii below. This part of the definition of “plan” may be limited to the hospital, medical and surgical benefits of the governmental program.

4. “Plan” shall not include:

- i. Individual or family insurance contracts;
- ii. Individual or family subscriber contracts;
- iii. Individual or family coverage through Health Maintenance Organizations (HMOs);
- iv. Individual or family coverage under other prepayment, group practice and individual practice plans;
- v. Group or group-type coverage where the cost of coverage is paid solely by the employee, member or subscriber;
- vi. Group hospital indemnity benefits of \$150.00 per day or less;
- vii. School accident-type coverages. This coverage provides benefits for students, headstart and day care enrollees, campers, and similar participants for accidents only, including athletic injuries, either on a 24-hour basis or on a “to and from school” basis;
- viii. A State plan under Medicaid; and
- ix. A plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

“Hospital indemnity benefits” means those benefits not related to expenses incurred. The term does not include expense-incurred benefits, even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

“Primary plan” means a plan whose benefits for a person’s health care coverage must be determined without taking into consideration the existence of any other plan. There may be more than one primary plan. A plan shall be a “primary plan” if either 1 or 2 below exists:

1. The plan has no order of benefit determination rules, or it has rules which differ from those permitted by this subchapter;
2. All plans which cover the person use the order of benefit determination rules required by this subchapter, and under those rules the plan determines its benefits first.

“Secondary plan” means a plan which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter shall decide the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of

the primary plan or plans and the benefits of any other plan which, under this subchapter, has its benefits determined before those of that secondary plan.

“This Plan” in a COB provision means the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits shall be separate from “This Plan”. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

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

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

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

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

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

11:4-28.3 Coordination permissive

(a) The use of COB provisions in group contracts providing health care benefits shall be permissive; any plan may elect to be always “primary”. Where COB is used, it shall be included in group contracts providing health care benefits subject to the following conditions:

1. If a group contract includes a COB provision, it shall be consistent with the requirements of this subchapter.
2. A plan that does not include a COB provision shall not take the benefits of another plan into account in determining its benefits.

(b) Group coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of a plan provided by the same contract holder.

11:4-28.4 Model COB contract provision

(a) Appendix A of this subchapter contains Model COB Provisions for use in group contracts, and is incorporated herein by reference as part of this subchapter. The use of the Model COB Provisions shall be subject to the provisions of (b) below, N.J.A.C. 11:4-28.5 and N.J.A.C. 11:4-28.6.

(b) A group contract’s COB provision shall not be required to use the words and format shown in Appendix A of this subchapter. Changes may be made to fit the language and style of the rest of the group contract or to reflect the differences among plans which provide services, pay benefits for expenses incurred, and which indemnify. No other changes to the Model COB Provisions in Appendix A shall be permitted.

11:4-28.5 Prohibited coordination; benefit design

(a) A group contract shall not reduce benefits on the basis that:

1. Another plan exists;
2. A person is or could have been covered under another plan, except with respect to Part B of Medicare; or
3. A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

(b) A contract shall not contain a provision that its benefits are “excess” or “always secondary” to any plan as defined in this subchapter, except as may be permitted by this subchapter. This prohibition shall not apply to group student excess accident or health contracts where no part of the premium is paid by the student or his family.

(c) No contract delivered or issued for delivery in this State, or renewed, continued or converted on or after January 1, 1991, shall contain any provision, rider, waiver or endorsement or other instrument which restricts, limits or excludes coverage, directly or indirectly, of services or expenses otherwise eligible under the contract on the grounds that such expenses or services would be covered under an automobile no-fault medical benefits plan for which the covered member would be eligible, except as provided for by N.J.A.C. 11:3-37.

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

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

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

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

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

11:4-28.6 Rules for coordination of benefits

(a) The general order of benefit determination shall be as follows:

1. The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist.
2. A secondary plan shall take the benefits of another plan into account only when, under this subchapter, it is secondary to that other plan.
3. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the plan which covers the person as a dependent.

(b) The rules for the order of benefits for a dependent child when the parents are not separated or divorced are as follows:

5. Inpatient and/or outpatient treatment for alcoholism as described at N.J.S.A. 17B:27-46.1 shall only be subject to pre-authorization provisions if all inpatient and/or outpatient treatments for other injuries and illnesses are subject to the same review.

(b) Incorporation of the required pre-authorization warning text in a certificate booklet, through certificate riders and/or insert pages shall not be acceptable.

(c) If an identification card is used for benefit certification purposes, a pre-authorization requirement warning similar to that contained in the policy and certificate shall be displayed on the identification card, along with a telephone number by which to contact the insurer regarding the pre-authorization provision.

1. A sample of the identification card along with a copy of any promotional and/or informational material which describes the preauthorization requirement shall be included with the initial form submission made to the Department.

11:4-42.9 Provisions for pre-existing condition exclusions and limitations

(a) Blanket and group policies and certificates providing life insurance or accidental death and dismemberment insurance benefits shall not subject such benefits to pre-existing condition exclusions and limitations.

(b) Group policies and certificates providing health insurance benefits, other than accidental death and dismemberment, may include pre-existing condition exclusions and limitations subject to the following:

1. A pre-existing condition may be defined no more restrictively than as an illness or injury for which the insured received treatment or advice from a physician or used prescription drugs within no more than a two year period prior to the effective date of coverage.

2. No policy, other than a policy providing group disability income insurance shall exclude coverage for a loss due to a pre-existing condition for a period greater than 24 months following the effective date of coverage, nor shall any policy provide any exclusion or limitation applicable to new losses due to a pre-existing condition after the 24-month (or lesser) period. Policies providing group disability income insurance may exclude coverage for losses beginning during the first 24 months after the effective date of coverage due to disabilities and recurrent disabilities which result from a pre-existing condition.

3. A succeeding insurer, in applying a pre-existing condition waiting period in its policy shall credit the covered person for satisfaction of the pre-existing condition waiting period under a prior policy or contract, or any portion thereof if the prior waiting period has not been satisfied in full.

4. No policy shall limit benefits to illnesses or injuries which first manifest themselves while the covered person is covered under the policy.

11:4-42.10 Provisions for subrogation and repayment of benefits

(a) Group policies and certificates providing health insurance may contain subrogation provisions or provisions that require the return to the insurer by a covered person of benefits paid for illness or injury up to the amount a covered person receives from a third party through settlement, a satisfied judgment or other means, as compensation for the medical costs of such illness or injury, subject to the following:

1. Repayment of benefits shall be required only where the amounts received for the third party through settlement, judgment or other means are specifically identified as amounts paid for health benefit which have been paid by the insurer under the group policy or certificate.

2. The repayment shall not exceed the amount of benefits paid by the insurer under the group policy or certificate for the particular illness or injury.

3. The group policy and certificate shall allow the covered person to deduct from the repayment to the insurer the reasonable pro-rata expenses incurred in effecting the third party payment.

(b) Group policies and certificates providing health insurance may exclude or reduce the health benefits payable to or on behalf of a covered person to the extent that the covered person has already received payment from a third party for past or future health care costs for an illness or injury resulting from the negligence or intentional act of such third party.

(c) Except as set forth in (b) above, no policy or certificate providing group health insurance shall limit or exclude health benefits as the result of the covered person's sustaining a loss attributable to the actions of a third party.

(d) Notwithstanding (a) or (b) above, disability income, long term care and accidental loss benefits and blanket insurance shall not be subject to subrogation or repayment of benefits received.

(e) Subrogation shall only be applicable when third party liability benefits may exist, subject to the restrictions set forth above.

11:4-42.11 Provisions concerning exclusions and limitations for the use of alcohol and drugs or relating to illegal occupations

(a) A blanket insurance policy or certificate or other group policy or certificate providing health insurance may include an exclusion for losses resulting from the covered

person's use of alcohol or drugs, but such exclusion shall be worded no more restrictively than as follows:

"The insurer shall not be liable for any loss sustained or contracted as a consequence of the covered person's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a physician."

(b) A group policy or certificate providing health insurance may include an exclusion for losses resulting from the covered person's involvement in an illegal activity, but such exclusion shall not be worded more restrictively than as follows:

"The insurer shall not be liable for any loss to which a contributing cause was the covered person's commission of or attempt to commit a felony or to which a contributing cause was the covered person's engagement in an illegal occupation."

(c) A blanket insurance policy or certificate or group policy or certificate providing health insurance shall not contain an exclusion for losses resulting from the covered person's incarceration or arrest, but benefits may be limited or excluded when the covered person is imprisoned as a result of his or her conviction of a crime.

11:4-42.12 Provisions for payment of benefits payable for automobile related injuries

(a) A group policy or certificate providing health insurance benefits shall not include any provision that restricts, limits, or excludes coverage of services or expenses, directly or indirectly, that otherwise are eligible under the policy or certificate on the grounds that such expenses or services would be covered under an automobile no-fault medical benefits plan for which the covered person would be eligible, nor shall the policy or certificate include an automobile no-fault medical plan for which the covered person would be eligible in the definition of "plan" in any coordination of benefits provision.

1. A group policy or certificate providing health insurance benefits shall contain the wording which appears in the Appendix to this subchapter, incorporated herein by reference, or any alternate wording that is at least as favorable to the covered person as the language contained in the Appendix, if the insurer intends to adjust its benefits by medical benefits payable under a group, group-type or individual automobile no-fault or traditional fault type contract.

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

(a) An insurer, in providing the conversion right required by N.J.S.A. 17B:27-19, shall treat the retirement of a covered person under a policy providing group life insurance as a termination of employment and shall permit the covered person to obtain, without evidence of insurability, an individual policy of life insurance.

(b) An insurer shall provide for a right of conversion to an individual policy for the amount of coverage that terminates when a covered person is transferred or transfers from one class of employee to another class of employee.

APPENDIX

BENEFITS PAYABLE FOR AUTOMOBILE RELATED INJURIES

1. Definitions.

"Automobile Related Injury" means bodily injury sustained by an insured as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered by this (policy/certificate) or PIP at least in part as an Eligible Expense.

"Eligible Expense" means that portion of expense incurred for treatment of an injury which is covered under this (policy/certificate) without application of deductibles or co-payments, if any.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP, as PIP is defined herein, including automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage (specifically those provisions for medical expense coverage) provided as part of an automobile insurance policy issued in New Jersey.

2. Application of this section.

When expenses are incurred as the result of an Automobile Related Injury, and the injured person has coverage under PIP or OSAIC, this section will be used to determine whether this (policy/certificate) provides coverage that is primary to such coverage or secondary to such coverage. It will also be used to determine the amount payable if this (policy/certificate) provides primary or secondary coverage.

3. Determination of primary or secondary coverage.

This (policy/certificate) provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the person covered under this (policy/certificate). This election is made by the named insured under a PIP policy and affects that person's family members who are not themselves named insureds under another automobile policy. This (policy/certificate) may be primary for one covered person, but not for another if the persons have separate automobile insurance policies and have made different selections regarding primacy of health coverage.

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

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

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

necessitate changes in that person's self-management, and upon determination of a State licensed physician or nurse practitioner/clinical nurse specialist that re-education or refresher education is necessary.

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

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

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