CHAPTER 4

ACTUARIAL SERVICES

Authority

(See subchapter level notes for specific authority.)

Source and Effective Date

R.1991 d.3, effective November 30, 1990.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).

Executive Order No. 66(1978) Expiration Date

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, expires on November 30, 1995.

Chapter Historical Note

Chapter 4, Actuarial Services, was filed and became effective prior to September 1, 1969. Pursuant to Executive Order No. 66, Chapter 4 was readopted by R.1991 d.3. See: Source and Effective Date. Subchapter 1, which was "Contracts on a Variable Basis," was repealed by R.1991 d.3, effective January 7, 1991.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). 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).

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. (RESERVED)

Subchapter Historical Note

Unless otherwise expressly noted, all provisions of subchapter 1 were adopted by the Commissioner, Department of Insurance, pursuant to authority delegated in c.122, P.L. 1959, sections 5(a)(iii), 5(b) and 5(e), and was filed and became effective prior to September 1, 1969. Subchapter 1 was repealed by R.1991 d.3, effective January 7, 1991.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 2. REPLACEMENT OF LIFE INSURANCE POLICY

Authority

N.J.S.A. 17B:30-1 et seq., 17:1C-6(e), and 17:1-8.1

Source and Effective Date

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).

Subchapter Historical Note

This subchapter was originally filed and became effective on April 1, 1972 as R.1972 d.21.

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. A signed statement as to whether or not the agent knows replacement is or may be involved in the transaction.

(b) Where a replacement is involved, the agent shall:

1. Present to the applicant, not later than at the time of taking the application, a "Notice Regarding Replacement of Life Insurance" in the form as described in Exhibit A or B of this subchapter, whichever is applicable, or other substantially similar form approved by the Commissioner. The Notice must be signed by and left with applicant.

2. Present to the applicant not later than at the time of taking the application, a Comparative Information Form as described in Exhibit D of this subchapter. (Substantially equivalent forms may be used with the prior approval of the Commissioner.) If more than one existing life insurance policy is to be replaced, a separate Comparative Information Form is to be provided for each such policy or separate information is to be provided in the Comparative Information Form for each such policy, and a summary of all the separate policy information to the extent possible must be included. The agent must include in the Comparative Information Form all of the information required to be in that Form, except that information concerning the existing life insurance policy that cannot be obtained from that policy itself. The Comparative Information Form must be signed by the agent and the applicant and a copy left with the applicant.

3. Leave with the applicant the original or a copy of all Sales Proposals used for presentation to the applicant.

4. Submit to the replacing insurer with the application, a copy of the "Notice Regarding Replacement of Life Insurance" signed by the applicant, a copy of the Comparative Information Form signed by the agent and the applicant, and a copy of all Sales Proposals used for presentation to the applicant.

(c) Each agent who uses a Sales Proposal when conserving existing life insurance shall:

1. Leave with the applicant the original or a copy of all Sales Proposals used in the conservation effort; and

2. Submit to the existing insurer a copy of all Sales Proposals used in the conservation effort.

11:4–2.5 Duties of replacing insurers

(a) Each replacing insurer shall:

1. Inform its field representatives of the requirements of this subchapter.

2. Require with or as part of each completed application for life insurance:

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

ii. A statement signed by the agent as to whether or not he or she knows replacement is or may be involved in the transaction.

3. Where a replacement is involved:

i. Require from the agent with the application for life insurance a copy of the "Notice Regarding Replacement of Life Insurance" signed by the applicant, a copy of the Comparative Information Form signed by the agent and the applicant, and a copy of all Sales Proposals used for presentation to the applicant.

ii. Verify the substantial accuracy of information concerning the proposed policy furnished to the applicant in the Comparative Information Form. If the information concerning that policy is not substantially accurate, the replacing insurer must obtain a Comparative Information Form signed by the agent and the applicant which includes substantially accurate information before it can begin to process the application for the proposed policy.

iii. Unless otherwise modified by the provisions of (a)3v or vi below, furnish to the applicant a Policy Summary in accordance with the provisions of the Life Insurance Solicitation Regulation.

iv. Send to the existing insurer a verified Comparative Information Form as required by (a)3i and ii above within three working days of the date the application and a substantially accurate Comparative Information Form are received at its Home or Regional Office, or the date its policy is issued, whichever is sooner.

v. Delay, if it is not also the existing insurer, the issue of its policy for 20 days after it sends the existing insurer a copy of the Policy Summary, unless it provides in its "Notice Regarding Replacement of Life Insurance" and in either its policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of 20 days commencing from the date of delivery of the policy, and it sends the Policy Summary required by this section to the existing insurer within three working days of the date its policy is issued, in which event the replacing insurer may issue its policy immediately.

vi. Provide, if it is also the existing insurer, the policy owner a Policy Summary for the new policy prepared in accordance with (a)3iii above, prior to accepting the applicant's initial premium or premium deposit, unless the replacing insurer provides in its "Notice Regarding Replacement of Life Insurance" and in either its policy or in a separate written notice that is delivered with the policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of 20 days commencing from the date of delivery of the policy, in which event, the replacing insurer must furnish the Policy Summary at or prior to delivery of the policy.

vii. Maintain copies of the "Notice Regarding Replacement of Life Insurance", the verified Comparative Information Form, the Policy Summary, and all Sales Proposals used, and a replacement register, cross indexed, by replacing agent and existing insurer to be replaced, for at least five years or until the conclusion of the next succeeding regular examination by the Insurance Department of its state or domicile, whichever is later.

11:4–2.6 Duties of insurers with respect to direct-response sales

(a) Each insurer shall:

1. Inform its responsible personnel of the requirements of this subchapter.

2. Require with or as part of each completed application for life insurance a statement signed by the applicant as to whether or not such insurance will replace existing life insurance.

3. Where no replacement is proposed by an insurer in the solicitation of a direct-response sale and a replacement is involved:

i. At the time the policy is mailed to the applicant, include a "Notice Regarding Replacement of Life Insurance" in a form substantially as described in Exhibit C of this subchapter.

4. Where a replacement is proposed by an insurer in the solicitation of a direct-response sale and a replacement is involved:

i. Request from the applicant with or as part of the application a list of all existing life insurance to be replaced. Such existing life insurance shall be identified by name of insurer.

ii. If the applicant furnishes the names of the existing insurers, then the replacing direct-response insurer shall mail the applicant a "Notice Regarding Replacement of Life Insurance" in a form substantially as described in Exhibit C of this subchapter within three working days after receipt of the application and shall comply with N.J.A.C. 11:4–2.5(a)3iii, v, vi and vii, except that it need not meet the requirements of this subchapter concerning Comparative Information Forms and need not maintain a replacement registered required by N.J.A.C. 11:4–2.5(a)3vii.

iii. If the applicant does not furnish the names of the existing insurers, then the replacing direct-response insurer shall at the time the policy is mailed to the applicant, include a "Notice Regarding Replacement of Life Insurance" in a form substantially as described in Exhibit C of this subchapter.

11:4–2.7 Duties of the existing insurer

(a) Each existing insurer shall inform its responsible personnel of the requirements of this subchapter. Each existing insurer, or such insurer's agent, that undertakes a conservation effort shall:

1. Within 20 days from the date the Comparative Information Form required by N.J.A.C. 11:4–2.5(a)3iv is received, either furnish the policyowner with the Comparative Information Form received from the replacing insurer and include in it all of the information concerning the existing life insurance that was not completed and correct any information that was inaccurately completed by the replacing agent or furnish the policyowner with a Policy Summary for the existing life insurance. The Policy Summary must be provided whenever the policyowner has indicated on the Comparative Information Form that he/she wishes to receive it. Such Policy Summary shall be completed in accordance with the provisions of the Life Insurance Solicitation Regulation, except that information relating to premiums, cash values, death benefits and dividends, if any, shall be computed from the current policy year of the existing life insurance. The Policy Summary shall include the amount of any outstanding policy indebtedness, the sum of any dividend accumulations or additions, and may include any other information that is not in violation of any regulation or statute. No charge may be made by the existing insurer for furnishing the Policy Summary.

2. Furnish the replacing insurer with a copy of the fully completed Comparative Information Form and the Policy Summary for the existing life insurance within three working days of the date that the fully completed Comparative Information Form and Policy Summary is sent by the existing insurer to either its agent or directly to the policyowner.

3. Maintain a file containing the following:

i. Comparative Information Forms required by N.J.A.C. 11:4–2.5(a)3iv and Policy Summaries required by N.J.A.C. 11:4–2.5(a)3v received from replacing insurers; and

ii. Copies of fully completed Comparative Information Forms and Policy Summaries prepared pursuant to (a)1 above, and all Sales Proposals used to conserve the existing life insurance.

(b) The material noted in (a)3i and ii above shall be indexed by the replacing insurer and held for five years or until the conclusion of the next regular examination conducted by the Insurance Department of its domicile, whichever is later.

11:4–2.8 Penalties

(a) Any insurer, agent, representative, officer or employee of such insurer failing to comply with the requirements of the subchapter shall be subject to such penalties as may be appropriate under the Insurance Laws of New Jersey.

(b) This subchapter does not prohibit the use of additional material other than that which is required that is not in violation of this subchapter or any other New Jersey Statute or regulation.

(c) Policyowners have the right to replace existing life insurance after indicating in or as part of the application for life insurance that such is not their intention; however, patterns of such action by policyowners who purchase the replacing policies from the same agent shall be deemed prima facie evidence of the agent's knowledge that replacement was intended in connection with the sale of those policies, and such patterns of action shall be deemed prima facie evidence of the agent's intent to violate this subchapter.

11:4–2.9 Separability

If any provisions of this subchapter shall be held invalid, the remainder of the subchapter shall not be affected thereby.

Exhibit A

(To be used where the existing and proposed policies are written by different companies.)
(Name, address and telephone number of the insurance company)

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

Our agent is recommending to you that you purchase a life insurance policy from us. In connection with this purchase, you have indicated either as a result of his recommendation or at your own initiative, that you may terminate or change your existing policy issued by another insurance company or that you may obtain a loan from that company against your policy to pay premiums on the proposed policy. Any of these actions is a replacement of life insurance. This notice must be given to you, along with a form including preliminary information comparing the proposed policy with your existing policy to be replaced. Please read this notice and a Comparative Information Form carefully.

Whether it is to your advantage to replace your existing insurance coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and of your existing insurance coverage.

To this end, we are required to give you a Policy Summary including complete information on the proposed policy no later than when the policy is delivered to you. In addition, we are required to notify the insurance company that issued your existing policy. That company may then furnish you with additional information concerning your existing policy. You may want to contact the company or its agent for further information and advice or discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision.

If either the proposed policy or the existing insurance you intend to replace is a participating policy, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should also recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misstatement or omission on your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have received your application and notified the other insurance company you will have 20 days from the date the proposed policy is delivered to you to cancel the policy issued on your application and receive back all payments you made to us.

(Alternate paragraph if 20–day money-back guarantee is not provided).

We are required by state regulation to delay the issuance of the policy for which you are making application for 20 days from the date on which we send your existing insurer notification that their policy will be replaced.

CAUTION:

If, after studying the information made available to you, you decide to replace the existing life insurance with our life insurance policy, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or able to purchase it only at substantially higher rates.

I have received and read a copy of this Replacement Notice.

(Signed) _____ Date _____

Exhibit B

(To be used where the existing and proposed policies are written by the same company.)

(Name, address and telephone number of the insurance company)

IMPORTANT NOTICE OF REPLACEMENT OF LIFE INSURANCE

Our agent is recommending that you purchase a life insurance policy from us. In connection with this purchase, you have indicated either as a result of his recommendation or at your own initiative, that you may terminate or change your existing policy issues by our company or that you may obtain a loan from our company against your existing policy to pay premiums on the proposed policy. Any of these actions is a replacement of life insurance. This notice must be given to you, along with a Comparative Information Form which includes preliminary information comparing the proposed policy with your existing policy to be replaced. Please read this notice and the Comparative Information Form carefully.

Whether it is to your advantage to replace your existing insurance coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and of your existing insurance coverage.

To this end, we are required to give you a Policy Summary including complete information on the proposed policy no later than when the policy is delivered to you. In addition, we will, at your request, furnish you additional information concerning your existing policy. You may want to discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision.

If either the proposed policy or the existing insurance you intend to replace is a participating policy you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should also recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which our company could contest the policy because of a material misstatement or omission on your application, or deny coverage for death by suicide may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

(Additional paragraph if 20–day money back guarantee is provided.)

After we have issued your policy, you will have 20 days from the date the new policy is delivered to you to cancel the policy issued on your application and received back all payments you made to us.

CAUTION:

If, after studying the information made available to you, you do decide to replace the existing life insurance with our company with a new life insurance policy issued by our company, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or able to purchase it only at substantially higher rates.

I have received and read a copy of this Replacement Notice.

(Signed) _____ Date _____

Exhibit C

(Name, address and telephone number of insurance company)

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

You have indicated that you intend to replace an existing life insurance policy or policies in connection with the purchase of our life insurance policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance coverage.

You may want to contact your existing life insurance company or its agent for additional information and advice or discuss purchase with other advisors. The information you received should be of value to you in reaching a final decision.

If either the proposed policy or the existing insurance you intend to replace is a participating policy, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because the rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could (contest the policy because of material misrepresentation or omission concerning the medical information requested in your application, or) [1] deny coverage for death caused by suicide, may have expired earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

(Additional paragraph if direct-response insurer's solicitation proposes replacement, and a 20–day money-back guarantee is provided by the insurer.)

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance coverage until you have been issued the new policy, examined it and have found it acceptable to you.

[1] Use parenthetical language only when the application asks health questions.

AGENT'S STATEMENT

1. The primary reasons for my recommending the proposed replacement of existing life insurance by new life insurance are: *

_____

_____

2. My recommendations as to the existing life insurance is that it be:
_____ Not Changed _____ Lapsed _____ Surrendered
_____ Reduced Paid–Up _____ Extended Term
Other (Explain) _____
Borrowed Upon (Explain), _____
3. The existing life insurance does not meet the insured/buyer's needs for insurance because: *

_____

_____

* Specific reasons must be given. For example, if you believe the existing life insurance cannot meet the insured/buyer's needs, you must specify why you think it does not.

INSTRUCTIONAL NOTES FOR AGENT

1. Existing life insurance must be identified by name of insurer and the policy number. In the event that a policy number has not been assigned by the existing insurer, alternative identification information such as an application or receipt number must be shown.

2. If a premium for the basic policy or any rider or benefit changes, indicate the changes; attach schedule, if necessary.

3. If the death benefit for the basic policy or any rider or benefit changes, indicate the changes; attach schedules, if necessary.

4. If the premium for benefits is not separable from the premium for the basic policy, insert "Included" in Basic Policy Premium.

5. If more than one existing life insurance policy is to be replaced, a separate Comparative Information Form is to be provided for each such policy, or separate information is to be provided in one Comparative Information Form for each such policy, and a summary of all the separate policy information must also be included to the extent possible.

Exhibit D

(Name, address and telephone number of insurance company)

COMPARATIVE INFORMATION FORM

Name of Proposed Insured _____ Address _____ Date of Birth _____

GENERAL INFORMATION	EXISTING LIFE INSURANCE	PROPOSED LIFE INSURANCE
Name of Company		
Policy Number		
Basic Policy Generic Name		
Name of Basic Policy		
Rider 1: Generic Name		
Rider 2: Generic Name		
Rider 3: Generic Name		
Issue Age		
Date of Issue		
Contestable Period Expires		
Suicide Clause Expires		

PREMIUM DATA/ DEATH BENEFITS	PREMIUM MODE: AMOUNT	AGE PAYABLE TO	DEATH BENEFIT	AGE BENEFIT CEASES	PREMIUM MODE: AMOUNT	AGE PAYABLE TO	DEATH BENEFIT	AGE BENEFIT CEASES
Basic Policy								
Basic Policy	$		$		$		$	
Rider 1	$		$		$		$	
Rider 2	$		$		$		$	
Rider 3	$		$		$		$	
Accidental Death Benefit	$		$		$		$	
Option to Purchase Additional Insurance	$		$ (Option Ages: ___)		$		$ (Option Ages: ___)	
Waiver of Premium Benefit	$		$xxx		$		$xxx	
Disability Income Benefit	$		$xxx (Monthly Income: $_____)		$		$xxx (Monthly Income: $_____)	
Total Current Premium	$							

CASH VALUES/ DIVIDENDS	*GUARANTEED CASH VALUE	*DIVIDENDS	*GUARANTEED CASH VALUE	*DIVIDENDS
Currently (last policy anniversary)	$	$	$	$
1 year hence	$	$	$	$
5 years hence	$	$	$	$
10 years hence	$	$	$	$
At age 65	$	$	$	$
*Current Death Benefit of Div. Adds			$	
*Current Cash Value of Div. Adds			$	
*Current Accum. Div.			$	
*Current Policy Loan			$	
Maximum Policy Loan Interest Rate _____%			Maximum Policy Loan Interest Rate _____%	

*Dividends are based on the current (19____) scale. *Dividends are based on the current (19____) scale.

*Dividends, policy loan and certain guaranteed cash value information concerning your existing insurance may not be known to our agent. Dividends are not guaranteed. However, they may materially reduce the cost of insurance and are an important factor to consider. Thus, if dividends or other figures have been omitted from this Comparative Information Form, you should not reach a final decision to replace your existing insurance until you have them. You may obtain the omitted figures from the company that issued your existing policy. We will notify that company of your intent to replace your existing policy.

AGENT'S CERTIFICATION

I hereby certify that prior to taking an application for a policy. I have provided the applicant with the Notice Regarding Replacement of Life Insurance and that the information in this Comparative Information Form is true and correct to the best of my knowledge and belief.

_____ _____

(Signature of agent) (Date)

APPLICANT'S CERTIFICATION

I have received and read a copy of this Comparative Information Form.

/ /I wish to receive

/ /I do not wish to receive

up-to-date cost index information in a Policy Summary for my existing policy(ies).

_____ _____

(Signature of Applicant) (Date)

SUBCHAPTER 3. COUPON POLICIES AND POLICIES CONTAINING GUARANTEED ANNUAL ENDOWMENT BENEFITS

Authority

Unless otherwise expressly noted, the provisions of this Subchapter 3 were adopted by the Commissioner, Department of Insurance, pursuant to authority delegated in c.66 and c.68, P.L. 1958 and c.379, P.L. 1947, and were filed July 17, 1963, and became effective August 1, 1963.

11:4–3.1 Payments

Payment of guaranteed annual endowment benefits in a policy shall not be made contingent on the payment of a premium falling due at the time such benefit would otherwise be payable or credited to the insured.

11:4–3.2 Gross premium shown

The gross premium for the guaranteed annual endowments shall be shown prominently and separately in the policy as distinct from the regular insurance gross premium.

11:4–3.3 Gross premium regarding additional insurance

The gross premium for any additional insurance effective after the first policy year, other than return of premiums, shall also be shown prominently and separately in the policy.

11:4–3.4 Coupons

Annual coupons for the guaranteed annual endowments shall not be included as a part of policies containing guaranteed annual endowments.

11:4–3.5 Guaranteed annual endowments

Guaranteed annual endowments shall not be included as benefits in policies entitled to participate in dividends.

11:4–3.6 Severability

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

11:4–3.7 Effective date

The effective date of this regulation shall be August 1, 1963.

SUBCHAPTER 4. PASSBOOKS USED IN CONNECTION WITH COUPON POLICIES OR POLICIES CONTAINING GUARANTEED ANNUAL ENDOWMENT BENEFITS

Authority

Unless otherwise expressly noted, all provisions of this Subchapter 4 were adopted by the Commissioner, Department of Insurance, pursuant to authority delegated in c.66 and c.68, P.L. 1958 and c.329, P.L. 1947 and were filed July 17, 1963 and became effective August 1, 1963.

11:4–4.1 General provisions

(a) Passbooks resembling those used for savings deposits in banks shall not be used in connection with policies to which this regulation applies which contain guaranteed annual endowment benefits.

(b) No reference shall be made in any material used in connection with such policies to "passbook" or "premium deposit" or other language which might give the impression to an applicant or person insured that the transaction involves premium deposits of a savings nature.

(c) The practice of using such books is determined to be an unfair method of competition and unfair or deceptive act or practice in the business of insurance in that it is a "statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby" as defined in section 4(1) of Chapter 379 of the Laws of 1947, Trade Practice Act, approved July 3, 1947.

11:4–4.2 Unfair practice

The use of such books as described in Section 4.1(a) (General Provisions) of this Chapter, is determined to be an unfair method of competition and unfair or deceptive act or practice under section 9 of Chapter 379 of the Laws of 1947, and such books shall not be used in connection with policies to which this regulation applies, as set forth in the Authority statement of this Subchapter.

11:4–4.3 Scope

(a) This practice shall be discontinued with respect to policies to which this regulation applies, as set forth in the Authority statement of this Subchapter because it conflicts with N.J.S.A. 17:34–15(c) and (d). Section 15c requires "that the policy constitute the entire contract between the parties".

(b) The reference to such language as "deposits" in such books, but not in the policy itself, is in conflict with the required provision that the policy constitute the entire contract.

11:4–4.4 Severability

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

11:4–4.5 Effective date

The effective date of this regulation shall be August 1, 1963.

SUBCHAPTER 5. AMENDMENT TO INSTRUCTIONS TO LIFE AND ACCIDENT AND HEALTH ANNUAL STATEMENT BLANK

Authority

Unless otherwise expressly stated, all provisions of this Subchapter 5 were adopted by the Commissioner, Department of Insurance, pursuant to the Authority delegated in N.J.S.A. 17:23–1 and 17:23–2 and c.379, P.L. 1947 and were filed November 18, 1963, and became effective December 2, 1963.

11:4–5.1 Amendment of instructions

The instructions for completing the Life and Accident and Health Annual Statement blank, relative to "net investment income", are amended by addition of the following paragraphs: "In lieu of the methods referred to above, an insurer may distribute net investment income by an investment year method which recognizes periodic variations in the yield on new investments, and the varying contributions of the various lines to the funds invested".

11:4–5.2 Approval by board of directors and Commissioner

(a) All domestic life and accident and health insurers proposing to use the above "investment year method" shall have such method approved by the insurer's board of directors.

(b) The method shall not become effective unless the proposed procedures shall have been submitted to and approved by the Commissioner.

11:4–5.3 "Investment year method," requirements

(a) All domestic and foreign and alien life and accident and health insurers electing to use the "investment year method" shall attach to the first annual statement to which the method is applicable a full description of the method used and a statement whether it has been specifically authorized by the law or insurance supervisory official of the state or other jurisdiction under whose laws the insurer was organized.

(b) In each year thereafter for which the "investment year method" continues in use unchanged, the insurer will certify to such continuance in an attachment to the annual statement of such year.

(c) For the first year it is not possible to furnish such certification, a full description of the method used must be attached to such year's annual statement.

11:4–5.4 Changing of method

(a) A domestic life or accident and health insurer, having adopted an "investment year method" shall not, without prior approval of the Commissioner:

1. Change to any other method; or
2. Revert to the traditional method.

11:4–5.5 Effective date

The effective date of this regulation shall be December 2, 1963.

SUBCHAPTER 6. RESERVE STANDARDS FOR INDIVIDUAL HEALTH INSURANCE POLICIES

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17B:19–5.

Source and Effective Date

R.1984 d.512, effective November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Subchapter Historical Note

All provisions of this subchapter were adopted by the Commissioner, Department of Insurance, pursuant to the authority delegated in c.66 and c.68, P.L. 1958 and Title 17, N.J.S.A., and were filed October 20, 1965, and became effective December 1, 1965. Amendments were filed and became effective November 5, 1984 as R.1984 d.512. See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

11:4–6.1 Purpose

Pursuant to N.J.S.A. 17B:19–5, the Commissioner of Insurance is authorized to promulgate rules establishing the minimum reserve standards and mortality, morbidity or other contingency bases which must be utilized by health insurers to calculate policy and loss reserves. This subchapter establishes such regulations.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

11:4–6.2 Scope

This subchapter applies to all insurers authorized to write health insurance in this State.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

11:4–6.3 Definitions

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

"1959 Accidental Death Benefits Table" is the minimum standard for accidental death benefits adopted by the National Association of Insurance Commissioners.

"Active life reserve" is the pro rata unearned premium reserve and the additional reserve required to fund the current cost of the future health benefits.

"Claim reserve" is the present value of amounts not yet due on claims and reserves for future contingent benefits.

"1964 Commissioner's Disability Table" is the minimum standard for total disability due to accident or sickness adopted by the National Association of Insurance Commissioners.

"Health Insurance" is defined at N.J.S.A. 17B:17–4.

"1974 Hospital Table" is the minimum standard for hospital expense benefits adopted by the National Association of Insurance Commissioners to replace the 1956 Inter–Company Hospital Table.

"1956 Inter–Company Hospital Table" is the minimum standard for hospital expense benefits adopted by the National Association of Insurance Commissioners.

"1956 Inter–Company Surgical Table" is the minimum standard for surgical expense benefits adopted by the National Association of Insurance Commissioners.

"Mortality table" is a table used to determine life expectancy.

"Morbidity table" is a table used to determine health expectancy.

"1974 Surgical Table" is the minimum standard for surgical expense benefits adopted by the National Association of Insurance Commissioners to replace the 1956 Inter–Company Surgical Table.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

11:4–6.4 Active life reserve-general

(a) Active life reserves are required for all in-force policies and are in addition to any reserves required in connection with claims.

(b) This subchapter contains minimum standards for active life reserves. Higher, adequate reserves shall be established by the insurer in any case where experience indicates that these minimum standards do not place a sound value on the liabilities under the policy.

As amended, R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).
This section was recodified from 6.1(a)-(c) with substantive changes.

11:4–6.5 Types of individual health insurance policies

(a) Type A are policies which are guaranteed renewable for life or to a specified age such as 60 or 65, at guaranteed premium rates.

(b) Type B are policies which are guaranteed renewable for life or to a specified age, such as 60 or 65, but under which the insurer reserves the right to change the scale of premiums.

(c) Type C are policies in which the insurer has reserved the right to cancel or refuse renewal for one or more reasons, but has agreed implicitly or explicitly that, prior to a specified time or age, it will not cancel or decline renewal solely because of deterioration of health after issue; however, policies shall not be considered of this type if the insurer has reserved the right to refuse renewal provided the right is to be exercised at the same time for all policies in the same category, unless premiums are based on the level premium principle.

(d) Type D are all other individual policies.

(e) The definitions set forth in (a) through (d) above do not classify "franchise" as a type of policy. Such policies are frequently written under an agreement limiting the insurer's right to cancel or refuse renewal. Usually the right is reserved to refuse renewal of all policies in the group or other categories such as those ceasing to be members of the association, and this would place such policies in Type D in accordance with the last clause under (c) above. However, if premiums are based on the level premium principle or if the renewal undertaking for the individual meets the requirements for Type A, B or C, the franchise policy should be so classified for reserve purposes.

(f) A policy may have guarantees qualifying it as Type A, B or C until a specified age or duration after which the guarantees, or lack of guarantees, may qualify it as Type A, B, C or D. In such case, the policy in each period shall be considered for reserve purposes according to the type to which it then belongs.

(g) Where all of the benefits of a policy, as provided by rider or otherwise are not of the same Type A, B, C or D, each benefit shall be considered for reserve purposes according to the type to which it belongs.

As amended, R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).
Recodified with substantive changes from 6.1(e) and Notes (a)-(c).

11:4–6.6 Reserve standards for policies of Type A, B or C

(a) The maximum interest rate for reserves shall be the maximum rate permitted by law in the valuation of currently issued life insurance.

(b) The mortality assumptions used for reserves shall be according to a table permitted by law in the valuation of currently issued life insurance.

(c) Morbidity or other contingency:

1. The minimum standard for total disability due to accident or sickness, shall be the 1964 Commissioner's Disability Table.

2. For policies issued prior to January 1, 1986, minimum standard for hospital expense benefits shall be the 1956 Inter–Company Hospital Table. For policies issued after December 31, 1985, the minimum standard for hospital expense benefits shall be the 1974 Hospital Table.

3. For policies issued prior to January 1, 1986, the minimum standard for surgical expense benefits shall be the 1956 Inter–Company Surgical Table. For policies issued after December 31, 1985, the minimum standard for surgical expense benefits shall be the 1974 Surgical Table.

4. The minimum standard for accidental death benefits shall be the 1959 Accidental Death Benefits Table.

5. As to all other benefits, the insurer shall adopt a standard which will produce reserves that place a sound value on the liabilities under such benefit.

(d) Negative reserves on any benefit may be offset against positive reserves for other benefits in the same policy, but the mean reserve on any policy shall never be taken as less than one-half the valuation net premium.

(e) The minimum reserve shall be on the basis of a two-year preliminary term.

(f) The reserve method shall be the mean reserves diminished by appropriate credit for valuation net deferred premiums. In no event, however, shall the aggregate reserve for all policies valued on the mean reserve basis, diminished by any credit for deferred premiums, be less than the gross pro rata unearned premiums under such policies.

(g) Provided the reserve on all policies to which the method or basis is applied is not less in the aggregate than the amount determined according to the applicable standards specified above, an insurer may use any reasonable assumptions as to the interest rate, mortality rates, or the rates of morbidity or other contingency, and may introduce an assumption as to the voluntary termination of policies. Also, subject to the preceding condition, the insurer may employ methods other than the methods stated above in determining a sound value of its liabilities under such policies, including but limited to the following:

1. The use of mid-terminal reserves in addition to either gross or net pro rata unearned premium reserves;

2. Optional use of either the level premium, the one-year preliminary term, or the two-year preliminary term method;

3. Prospective valuation on the basis of actual gross premiums with reasonable allowance for future expenses;

4. The use of approximations such as those involving age groupings, groupings of several years of issue, average amounts of indemnity;

5. The computation of the reserve for one policy benefits as a percentage of, or by other relation to, the aggregate policy reserves, exclusive of the benefit or benefits so valued;

6. The use of a composite annual claim cost for all or any combination of the benefits included in the policies valued.

(h) For statement purposes the net reserve liability may be shown as the excess of the mean reserve over the amount of net unpaid and deferred premiums, or, regardless of the underlying method of calculation, it may be divided between the gross pro rata unearned premium reserve and a balancing item for the "additional reserve."

As amended, R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).
Recodified from 6.1(f) with substantive changes.

11:4–6.7 Reserve standards for policy Type D

The minimum reserve standard for policy Type D shall be the gross pro rata unearned premium.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

11:4–6.8 Claim reserves—present value of amounts not yet due on claims

(a) Reserves are required for claims on all health insurance policies, whether of Type A, B, C or D, providing benefits for continuing loss, such as loss of time or hospitalization.

(b) As to claim reserve standards for total disability due to accident or sickness, the following rules shall apply:

1. The maximum interest rate for reserves shall be the maximum rate permitted by law in the valuation of life insurance issued on the date of the health insurance.

2. The reserve shall be established in accordance with the 1964 Commissioner's Disability Table, except that for unreported claims and resisted claims and, at the option of the insurer, claims with a duration of disablement of less than two years, reserves may be based on the individual insurer's experience or other assumptions designed to place a sound value on the liabilities. Reserves based on such experience or assumptions shall be verified by the development of each year's claims over a period of years.

3. For policies with an elimination period, the duration of disablement shall be considered as dating from the time that benefits would have begun to accrue had there been no elimination period.

4. A new disability connected directly or indirectly with a previous disability which had a duration of at least one year and terminated within six months of the new disability shall be considered a continuation of the previous disability.

(c) As to reserve standards for all other claim reserves, the following rules shall apply:

1. The maximum interest rate for reserves shall be the maximum rate permitted by law in the valuation of life insurance issued on the date of the health insurance.

2. The reserve shall be based on the individual insurer's experience or other assumptions designed to place a sound value on the liabilities. The results shall be verified by the development of each year's claims over a period of years along the lines of Schedule O.

(d) As to valuation procedures, the insurer may employ suitable approximations and estimates, including but not limited to groupings and averages, in computing claim reserves.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).
Section recodified from 6.2; Old 6.8 was repealed.

11:4–6.9 Loss of time policies

In the case of loss of time policies containing a change or changes in the premium or benefits after a fixed duration of coverage prior to the terminal age, the reserves shall be calculated along the principles set forth on page 160 of the 1941 Proceedings of the National Association of Insurance Commissioners.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).
Recodified from 6.3.

11:4–6.10 Tabular reserves, deficiency reserve requirement

Because of the aggregate and average nature of tabular reserves, no deficiency reserves will be required, even though for some ages and plans for some classifications of risks the premiums charged may be less than the tabular net premiums.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).
Recodified from 6.4.

11:4–6.11 Commissioner's Disability Table

The 1964 Commissioner's Disability Table shall be used without adjustment as the minimum standard for women as well as men.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).
Recodified from 6.5.

11:4–6.12 Active life reserve factors, elimination period

The active life reserve factors for disability benefits with an elimination period of seven days shall be considered generally appropriate for benefits with a shorter or no elimination period.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).
Recodified from 6.6.

11:4–6. Policy applicability

The reserve standards set forth in this regulation shall apply to policies issued on or after January 1, 1965, and, at the option of the insurer, for prior issues.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).
Recodified from 6.7.

11:4–6.14 Severability

If any provision of this subchapter or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect other provisions or applications of the subchapter which can be given effect without the invalid provision or application and to this end, the provisions of this subchapter are severable.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

SUBCHAPTER 7. PROCEDURE FOR THE REGULATION OF CONSENT TO HIGHER RATE FILINGS

Authority

Unless otherwise expressly noted, all provisions of this Subchapter 7 were adopted by the Commissioner, Department of Insurance, pursuant to authority delegated in N.J.S.A. 17:1–8.1 and 17:1C–6(e) and were filed March 23, 1973, as R.1973 d.82 and became effective April 15, 1973, for automobile insurance and July 1, 1973, for all other lines of insurance. (See: 4 N.J.R. 220(a), 5 N.J.R. 113(b).)

11:4–7.1 Filing requirements

(a) Every application must be filed with the Commissioner of Insurance within 20 work days after the insured has signed it or within 20 work days of the inception date of the policy, whichever is earlier.

(b) Each application shall show the following information:

1. Name and address of company, and signature by authorized company representative;

Name, address, New Jersey license number and signature of producer;

3. Name and address of insured;

4. Effective date and expiration date of policy;

5. Policy number, if available;

6. Coverages applied for, including limits, amounts of insurance, deductibles, and so forth;

7. Exposure identification class, territory, description and use of automobile, and so forth;

8. Premiums:

i. The premium developed by the rating system approved for the company for the coverages applied for, identified as "Normal Premium";

ii. The additional premium to be charged in consideration of the additional hazard, identified as "Additional Premium";

iii. The total of the two amounts identified as "Premium Payable".

9. Underwriting information in support of the additional premium under (a)8ii above. In the case of automobile insurance, liability and physical damage, a copy of the abstract of driving record from the Division of Motor Vehicles shall be submitted. Such abstract is not required if the coverage applied for is excess coverage over the coverages and limits available under any residual market mechanism providing automobile insurance pursuant to statute. In the case of fire insurance, an inspection report, based upon an inspection performed by a qualified person, shall be submitted.

10. Each application shall be signed by the insured and it shall contain the following statement:

"I consent to the premium shown as 'Premium Payable' on this application which is higher than would normally apply because of the greater hazard involved."

11. The application form shall contain the following statement signed by the producer of record (broker or agent) or by an officer of the company providing the coverage:

"Under penalty of N.J. 17:29A–16 and N.J. 17:29A–22, I declare that this application was fully completed as shown, before signed by the applicant."

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).
In (b): deleted "New Jersey Automobile Insurance Plan" and added text regarding "any residual market mechanism."

11:4–7.2 Premium charges

(a) Premium charges in excess of those produced by the rating system approved for the submitting company shall be reasonable and adequate and not unfairly discriminatory, and shall be proportionate to the additional hazard, subject to the following provisions on business for which coverage is available under any residual market mechanism created by statute, including, but not limited to, the New Jersey Underwriting Association under the Fair Plan and the Crime Indemnity Plan:

1. Insurance available from these plans shall be rated in accordance with the rating systems approved for these facilities and the procedures applicable to such business shall be followed, if written under the Consent to Higher Rate provision. Any surcharges to be applied to such business must be documented by any required inspection report.

2. An insured qualifying for coverage under these plans shall not be offered coverage at lower limits, lower amounts or otherwise reduced coverage except at a proportionate reduction in the otherwise applicable premium.

3. If an insured eligible for insurance from these plans requests limits or amounts of insurance higher than available thereunder, the excess portion may be written at rates higher than produced by the company's rating system, subject to the standards set forth above.

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).
In (a): deleted "New Jersey Automobile Insurance Plan" and added text regarding "any residual market mechanism..."
In (a)1: deleted text defining documentation by motor vehicle reports for automobile insurance and reference to cases of fire and crime insurance.

11:4–7.3 Approval of applications

(a) Applications complying with the above rules will be approved by the Commissioner of Insurance on a current basis and the submitting carrier can expect to be notified promptly of such action.

(b) Applications that fail to comply with any of the above requirements or do not meet the requirement of being reasonable and adequate and not unfairly discriminatory will be disapproved. Notification of such disapproval will be sent by the Commissioner to the company, the producer of record and the insured.

(c) The company and the insured shall have the same legal remedies as are available in the case of disapproval of any rate filing.

(d) If a filing is disapproved, the policy with respect to which the filing had been made may be cancelled by the company on the basis of the premium that is applicable under the rating system approved for the company (normal premium), but such cancellations must be on a *pro rata* basis. However, if a disapproval is sustained upon an appeal by the insured, cancellation shall be *pro rata* on the basis of the "premium payable" as defined above.

(e) If the company wishes to continue the policy in force after the "consent to rate" filing has been disapproved, it may do so by charging the normal premium as of the policy's inception date.

(f) Nothing in this regulation shall prevent a company from filing a rate that produces a premium lower than that produced by the approved rating system, including the rating systems applicable under any residual market mechanism created by statute, including, but not limited to, the Fair Plan and the Crime Indemnity Plan.

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).
In (f): deleted text regarding "New Jersey Automobile Insurance Plan" and added reference to "... any residual market ... but not limited to."

SUBCHAPTER 8. CHARITABLE ANNUITIES

Authority

Unless otherwise expressly noted, all provisions of this Subchapter were adopted pursuant to authority delegated at N.J.S.A. 17:1–8.1 and 17:1C–6(e) and were filed and became effective September 20, 1974, as R.1974 d.258. See: 6 N.J.R. 315(a), 6 N.J.R. 399(c).

11:4–8.1 Purpose

(a) N.J.S.A. 17B:17–13.1 provides that qualified organizations as defined therein may enter into annuity agreements under conditions which are different from those which are applicable to organizations which are deemed to be insurers. This subchapter protects the interest of individual holders of annuities and their beneficiaries by requiring:

1. The use of forms which clearly set forth the conditions of the agreement being entered into;

2. The maintenance of segregated assets in such form and such amount as will protect the interest of the annuitants; and

3. The submission to the Commissioner, by the issuers of charitable annuities, of periodic reports which will enable the Commissioner to determine that the requirements of law and of this subchapter are being met.

(b) Charitable annuities are different from other annuities in that a significant part of the consideration paid for the annuity represents a gift to the issuing organization. In order to assure that such a gift results, this subchapter specifies maximum rates of income to annuitants for charitable annuities.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Deleted text in subsection (a).

11:4–8.2 Forms of agreement

An applicant for a special permit shall submit, with his application to the Commissioner, a copy of each form of agreement which it proposes to issue to annuitants. If a holder of a special permit proposes to institute a new form of agreement with annuitants, the form shall first be submitted to the Commissioner for his approval before it is put into use.

11:4–8.3 Annuity rates

(a) The original consideration for periodic payments payable to the holder of a charitable annuity may not be less than the net single premium, computed according to interest and mortality assumptions permitted by N.J.S.A. 17B:19 for guaranteed periodic payments, plus a life insurance net single premium, computed according to the same assumptions for an amount of death benefit equal to one-half of such original consideration. For this purpose the original consideration shall include the gross amount paid by the annuitant to the special permit holder in order to provide the annuity payments and the residue.

1. A special permit holder, proposing to use the rates adopted by the Conference on Gift Annuities, must demonstrate to the Commissioner that these rates meet the above requirements.

(b) An applicant for a special permit shall submit, with his application to the Commissioner, a schedule of its annuity rates for each form of annuity that it proposes to issue.

(c) A special permit holder which adopts rates for a proposed new form of annuity or which proposes to change the rates on its existing annuities shall submit such rates to the Commissioner for his approval before they become effective.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added (a)1.

11:4–8.4 Surplus and reserves

(a) Each special permit holder shall have and maintain segregated assets at least equal to the sum of:

1. The reserves on its outstanding agreements calculated in accordance with the provisions of N.J.S.A. 17B:19; and

2. A surplus equal to $100,000 or to ten per cent of the amount in paragraph 1 above, whichever is greater.

(b) In determining the reserves of any special permit holder, a deduction shall be made for all or any portion of an annuity risk which is lawfully reinsured by an authorized insurer, but such reinsurance shall not relieve a special permit holder from the requirement that the surplus shall be at least $100,000.

(c) The Commissioner may consider that each corporation or association in a group of two or more corporations and/or associations which has met all other requirements of this section has met the requirements as to the amount of segregated annuity fund assets, provided:

1. The segregated assets of each such organization shall equal at least 110 per cent of the sum of the reserves on its outstanding agreements calculated in accordance with the provisions of N.J.S.A. 17B:19;

2. The combined segregated assets of all such organizations, when considered as a unit, meet the requirements of this section concerning the amount of segregated assets;

3. The organizations enter into an agreement by which each organization pledges the full amount of its segregated annuity assets as liable for the payment of each annuity and all annuities issued under the agreement by each organization and all organizations in the group;

4. Such agreement shall be determined by the Commissioner to protect the public at least to the same extent as though all annuities were issued by a single organization;

5. No change may be made in such agreement and no organization may be added to or released from such agreement without the prior approval of the Commissioner; and

6. The Commissioner may require that, in addition to any other reports that he shall normally require from permit holders, the group of organizations file annually a consolidated report in order to demonstrate that the requirements of this section are met on a consolidated basis.

(d) Each member organization within the group will be subject to all requirements of the law and of this subchapter other than the requirement of $100,000 minimum surplus; this minimum must be satisfied by the group, however.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added "N.J.S.A. 17B–19".

11:4–8.5 Compliance with investment requirements

The segregated assets held by a special permit holder shall be invested in the same manner and subject to the same restrictions as provided in N.J.S.A. 17B:20 for domestic insurers, unless more restrictive provisions are contained in applicable statutes regulating any such special permit holder.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added "N.J.S.A. 17B–20". Deleted text "However, prior to ... chapter 19 of the code."

11:4–8.6 Annual report

(a) As of December 31 of the calendar year in which a special permit is issued, and as of December 31 of each succeeding calendar year, the holder of a special permit shall submit a report to the Commissioner. Such report shall be submitted to the Commissioner within 120 days following the end of the calendar year to which the report applies. The annual report shall be in such form as the Commissioner shall prescribe within three months prior to the end of each preceding calendar year.

(b) Each special permit holder shall submit, as part of the annual report, a statement by a qualified actuary setting forth his or her opinion as to the adequacy of reserves. A qualified actuary for the purpose of this subsection means a member in good standing of the American Academy of Actuaries, or a person who has otherwise demonstrated his or her actuarial competence to the satisfaction of the insurance regulatory official of the domiciliary state.

(c) Each domestic special permit holder shall submit, as part of the statement by the qualified actuary, a copy of the workpapers used by the actuary to calculate the required reserves.

(d) Each special permit holder shall respond on a timely basis to any inquiry of the Commissioner, or his designee, regarding the annual report.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added (b)-(d).

11:4–8.7 Special permit

Anything in this subchapter to the contrary notwithstanding, no organization referred to by N.J.S.A. 17B:17–13.1 may enter into annuity agreements with donors until it has satisfied the Commissioner of Insurance that it satisfies all of the requisite provisions of the law and has received from the Commissioner a special permit authorizing it to do such business.

Amended by R.1985 d.94, effective March 18, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added "N.J.S.A. 17B:17–13.1."

11:4–8.8 Separability of provisions

If any provision of this subchapter or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect the provisions or applications of this subchapter which can be given effect without the invalid provision or application, and for this purpose the provisions of the subchapter are separable.

Amended by R.1985 d.94, effective March 18, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Deleted "regulation" and substituted "subchapter".

11:4–8.9 Penalties

Failure to comply with the provisions of this subchapter will subject any special permit holder to the penalties provided by N.J.S.A. 17B:17–13.1d and any other penalties available to the Commissioner of Insurance.

Amended by R.1985 d.94, effective March 18, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Deleted "Effective date" rule and substituted "Penalties".

SUBCHAPTER 9. PERSONAL LINES INSURANCE: PROSPECTIVE LOSS COSTS FILING PROCEDURES

Authority

N.J.S.A. 17:1C–6(e), 17:1C–8.1 and 17:29A–1 et seq.

Source and Effective Date

R.1995 d.406, effective August 7, 1995.
See: 27 N.J.R. 1356(b), 27 N.J.R. 2931(a).

11:4–9.1 Purpose and scope

(a) This subchapter establishes data requirements and filing procedures for participating insurers in rating organizations to adopt or modify a rating organization's approved prospective loss costs.

(b) This subchapter applies to all rating organizations which file prospective loss costs and all insurer filings which adopt or modify a rating organization's prospective loss cost filing for personal lines property/liability insurance made pursuant to N.J.S.A. 17:29A–1 et seq. This does not apply to private passenger automobile insurance rate filings for which the use of rating organizations are specifically prohibited by N.J.S.A. 17:33B–31.

(c) All filings made pursuant to this subchapter shall be made in accordance with N.J.S.A. 17:29A–1 et seq., N.J.A.C. 11:1–2 and 11:1–32.

11:4–9.2 Definitions

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

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

"Department" means the New Jersey Department of Insurance.

"Expenses" means that portion of a rate attributable to commissions and brokerage, other acquisition expenses, general expenses, taxes, licenses, and fees.

"Loss costs multiplier" means the adjustment reflecting expenses, profit loading and any modifications that the insurer uses on the loss costs to produce final rates.

"Minimum premium" means the smallest amount of premium for which an insurer will issue coverage under a given policy.

"Prospective loss costs" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

"Rate" means the unit charge by which the measure of exposure or the amount of insurance specified in a policy of insurance or covered thereunder is multiplied to determine the premium. The unit charge may be expressed as a single number or as a prospective loss cost and an adjustment to account for the treatment of expenses, profit and variations in loss experience.

"Rating organization" means every person or persons, corporation, partnership, company, society, or association engaged in the business of ratemaking for two or more insurers.

"Supplementary rate information" means any manual or plan of rates, statistical plan, classification, rating schedule, rating rule and any other rule used by an insurer in making rates. This includes policy-writing rules, rating plans, territory codes and descriptions, and rules which include factors or relativities such as increased limits factors, classification relativities or similar factors used to determine the rate in effect or to be in effect.

11:4–9.3 Prospective loss cost filing requirements for rating organizations

(a) A rating organization that desires to file prospective loss costs with the Commissioner shall develop a filing containing advisory prospective loss costs and supporting actuarial and statistical data.

(b) Rating organizations that file advisory prospective loss cost filings with the Commissioner shall:

1. Submit a filing that contains the advisory prospective loss costs and the underlying loss data and other supporting actuarial information for any calculations or assumptions underlying those loss costs. Filings of prospective loss costs shall be filed and become effective in accordance with N.J.S.A. 17:29A–1 et seq. and N.J.A.C. 11:1–2; and

2. No longer develop or file minimum premiums with the filing of prospective loss costs.

(c) A rating organization may print and distribute manuals of prospective loss costs, as well as rules and other supplementary rate information filed and approved pursuant to N.J.S.A. 17:29A–1 et seq.

(d) Rating organizations shall continue to develop and file rules, relativities and other supplementary rate information on behalf of their member/subscriber insurers.

11:4–9.4 Prospective loss costs filing requirements for insurers

(a) In order for an insurer to incorporate a rating organization's approved prospective loss costs to establish its own rates, an insurer shall:

1. Be a participating insurer in the rating organization; and

2. File its loss costs multiplier using the Filing Adoption Form (as set forth in Appendix A to this subchapter and incorporated herein by reference). An insurer's loss costs multiplier shall be filed and become effective in accordance with N.J.S.A. 17:29A–1 et seq. and N.J.A.C. 11:1–2. An insurer's final rates shall be a combination of the approved prospective loss costs and the approved loss costs multiplier.

i. An insurer may file modifications to the rating organization's approved prospective loss costs filing based on its own anticipated experience by using the Filing Adoption Form. Supporting documentation shall be filed for any modification (upwards or downwards) to the rating organization's prospective loss cost filings.

ii. An insurer's approved loss costs multiplier shall remain in effect until the insurer withdraws the multiplier or until a revised Filing Adoption Form is filed by the insurer and approved by the Department.

(b) An insurer may vary expense loads by individual lines, sublines or classifications of insurance. An insurer may use variable or fixed expense loads or a combination of these to establish its expense loadings by using the Filing Adoption Form, items 17–21.

1. An insurer's loss cost multiplier based on its expenses plus any profit provision shall not include the automobile insurance surtax pursuant to N.J.S.A. 17:33B–49, the Property–Liability Insurance Guaranty Association's assessments on private passenger automobiles pursuant to N.J.S.A. 17:30A–8a(9), and recoupment of paid apportioned shares of Market Transition Facility losses and expenses pursuant to N.J.S.A. 17:33B–11d.

2. An insurer shall provide documentation to support its profit loading, which shall demonstrate how the insurer reflects investment income.

3. An insurer shall provide the overall dollar impact and the number of New Jersey policies affected by the filing.

(c) Any participating insurer of a rating organization shall continue to use all rates and deviations currently in effect for its use until disapproved pursuant to N.J.S.A. 17:29A–14 or until the insurer revises its rates, either upon approval of an independent filing or upon approval of a Filing Adoption Form.

(d) Once an insurer has an approved loss costs multiplier on file with the Department, such multiplier shall be deemed to be automatically applicable to subsequent rating organization prospective loss costs filings, subject to the following requirements:

1. An insurer which intends to use a subsequent revision of approved prospective loss costs and the effective date of the rating organization shall not file anything unless final printed rate pages were previously submitted. If final printed rate pages were previously submitted, then new rate pages shall then be submitted to reflect the revision;

2. An insurer, which intends to use a subsequent revision of approved prospective loss costs but with a different effective date, shall file with the Department its proposed effective date before the effective date of the rating organization's prospective loss costs;

3. An insurer which intends to use a subsequent revision of approved prospective loss costs and to change its loss costs multiplier shall file a revised Filing Adoption Form for approval in accordance with N.J.S.A. 17:29A–1 et seq. and N.J.A.C. 11:1–2 before the effective date of the rating organization's prospective loss costs filing; and

4. An insurer, which does not intend to use a subsequent revision of approved prospective loss costs, shall notify the Department before the effective date of the rating organization's prospective loss costs filing. The insurer shall file a Non–Adoption of Prospective Loss Cost Form (as set forth in Appendix B to this subchapter and incorporated herein by reference) with the Department.

(e) When filing to adopt a rating organization's prospective loss cost filing, the insurer shall also file with the Department, within 30 days of the effective date of the insurer's rates, either:

1. A final printed manual page indicating the loss cost multiplier to be applied to the rating organization's prospective loss costs, including its effective date; or

2. Final printed manual pages indicating the final rates developed by application of the loss cost multiplier to the rating organization's loss costs, including the effective date.

11:4–9.5 Penalties

Rating organizations and insurers which fail to comply with the filing submission requirements of this subchapter shall be subject to penalties as provided by law.

APPENDIX A

Space Reserved for Insurance Department Use

Date of filling out Form: _____

NEW JERSEY INSURER RATE FILING
ADOPTION OF ADVISORY ORGANIZATION
PROSPECTIVE LOSS COSTS
FILING ADOPTION FORM

1. INSURER NAME _____
   ADDRESS _____
   _____
   _____
   _____
   _____
   PERSON RESPONSIBLE FOR FILING _____
   TITLE _____ TELEPHONE # _____

2. INSURER GROUP NAIC # _____

2A. INSURER COMPANY NAIC# _____

3. LINE OF INSURANCE _____

4. ADVISORY ORGANIZATION _____

5. ADVISORY ORGANIZATION REFERENCE FILING # _____

6. The above insurer hereby declares that it is a member, subscriber or service purchaser of the named advisory organization for this line of insurance. The insurer hereby files to be deemed to have independently submitted as its own filing the prospective loss costs in the captioned Reference Filing.

   The insurer's rates will be the combination of the prospective loss costs and the loss cost multipliers.

7. PROPOSED RATE LEVEL CHANGE _____% EFFECTIVE DATE_____

8. PRIOR RATE LEVEL CHANGE _____% EFFECTIVE DATE_____

9. ATTACH "FILING ADOPTION FORM" FOR EACH INSURER *IF SELECTED LOSS COST MULTIPLIER IS DIFFERENT.*

** The Filed Loss Cost Level Change Factor for the initial filing is the Ratio of Revised Loss Costs to Current Rates divided by the Deviation which the insurer applied to the Current Rates (expressed as a decimal); and for subsequent filings, the Ratio Loss Cost Level to Current Loss Cost Levels.

Insurer Name: _____ Date of filling out Form: _____

NAIC #: Group:- Company:-

NEW JERSEY INSURER RATE FILING
ADOPTION OF ADVISORY ORGANIZATION PROSPECTIVE LOSS COSTS
PROSPECTIVE LOSS COSTS
FILING ADOPTION FORM

CALCULATION OF COMPANY LOSS COST MULTIPLIER

10. Line, Subline, Coverage, Territory, Class, etc. combination to which this page applies:

_____

11. Loss Cost Modification:
A. The insurer hereby files to adopt the prospective loss costs in the captioned reference filing: (CHECK ONE)

Without modification. *(Factor = 1.000)*

With the following modification(s). *(Cite the nature and percent modification and attach supporting data and/or rationale for the modification.)*

_____

_____

B. Loss Cost Modification Expressed as a Factor: _____
(See examples below.)

NOTE: IF EXPENSE CONSTANTS ARE UTILIZED, ATTACH "EXPENSE CONSTANT SUPPLEMENT" OR OTHER SUPPORTING INFORMATION, AND DO NOT COMPLETE ITEMS 12–16 BELOW.

12. Development of Expected Loss Ratio.
(Attach exhibit detailing insurer expense data and/or other supporting information.)

	Selected Provisions
A. Total Production Expense	_____%
B. General Expense	_____%
C. Taxes, Licenses & Fees	_____%
D. Profit & Contingencies*	_____%
E. Other (explain)	_____%
F. TOTAL	_____%

13A. Expected Loss Ratio: ELR = 100% – 12F = _____%
13B. ELR in decimal form = _____%

14A. Company Loss Cost Multiplier: (11B/13B) = _____
14B. Company Selected Loss Cost Multiplier = _____

15. Company Current Loss Cost Multiplier *(Only on subsequent Loss Cost Filings):* _____

16. Rate level change for the coverages to which this page applies: _____%
i.e. [(14B/15) x Filed Loss Cost Level Change Factor – 1.00].
Note that for the initial Loss Cost Filing, Item 15 = 1.000).

Example 1: Loss Cost modification factor: If your company's loss cost modification is – 10%, a factor of 0.9 (1.000 – .100) should be used.
Example 2: Loss Cost modification factor: If your company's loss cost modification is + 15%, a factor of 1.15 (1.000 + .150) should be used.

* This should reflect investment income.

Insurer Name: _____ Date of filling out Form: _____

NAIC #: Group:- Company:-

NEW JERSEY EXPENSE CONSTANT SUPPLEMENT

CALCULATION OF COMPANY LOSS COST MULTIPLIER

17. Development of Expect Loss Ratio.
(Attach exhibit detailing insurer expense data and/or other supporting information).

		Selected Provisions	
	Overall	Variable	Fixed
A. Total Production Expense	_____%	_____%	_____%
B. General Expense	_____%	_____%	_____%
C. Taxes, Licenses & Fees	_____%	_____%	_____%
D. Underwriting Profit & Contingencies	_____%	_____%	_____%
E. Other (explain)	_____%	_____%	_____%
F. TOTAL	_____%	_____%	_____%

18A. Expected Loss Ratio: ELR = 100% - Overall 17F = _____%

B. ELR expressed in decimal form = _____

C. Variable Expected Loss Ratio VELR = 100% - Variable 17F = _____%

D. VELR in decimal form = _____

19. Formula Expense Constant:
[(1.00 / 18B) - (1.00 / 18D)]* Average Prospective Loss Cost = _____

Formula Variable Loss Cost Multiplier: (11B / 18D) = _____

20. Selected Expense Constant = _____

Selected Variable Loss Cost Multiplier = _____

21. Rate level change for the coverages to which this page applies _____%

APPENDIX B

NEW JERSEY FORM NA—1

NON-ADOPTION OF PROSPECTIVE LOSS COST

1. Insurer: _____ NAIC#: _____

2. Rating Organization Affiliation: _____

3. Line of Insurance: _____

4. Rating Organization Designation Number: _____

5. Effective Date of Non-Adoption: _____

6. Rating Organization Designation Number Currently Being Used: _____

7. Effective Date of Use: _____

SUBCHAPTER 10. EXPENSE EXPERIENCE

11:4–10.1 Reporting of expense experience

(a) The portion of the publication cited below shall serve as the basis for recording and reporting of expense experience as contemplated in N.J.S.A. 17:29A–5 for use in examination of and rate-making by property-liability insurers:

1. National Association of Insurance Commissioners Examination Handbook, Part C, pages C1–C54, and any amendments thereto: "Instructions for Uniform Classifications of Expenses", and "Interpretations of Uniform Accounting Instructions".

(b) This rule has been known as "Regulation 30" since the National Association of Insurance Commissioners adopted the uniform classification of expenses.

R.1975 d.211, eff. July 23, 1975.
See: 7 N.J.R. 275(a), 7 N.J.R. 370(a).

11:4–10.2 Notice required

Any company that is currently compiling or intends to compile for the ensuing year for use in rate-making in New Jersey, insurance expense data in greater detail as to state, classification group or line of insurance than provided in the insurance expense exhibit shall notify the commissioner of this fact each year on or before September 15. This requirement applies to all expense categories set forth in the instructions for uniform classification of expenses of fire and casualty insurance on file with this department in accordance with N.J.A.C. 11:4–10.1, except commissions and allocated loss adjustment expenses.

R.1977 d.358, eff. September 21, 1977.
See: 9 N.J.R. 371(a), 9 N.J.R. 481(b).

SUBCHAPTER 11. LIFE INSURANCE SOLICITATION

Authority

Unless otherwise expressly noted, all provisions of this subchapter were adopted pursuant to authority of N.J.S.A. 17:1–8.1, 17:1C–6(e) and 17B:30–1 et seq. and were filed and became effective on October 18, 1976 (except as otherwise provided herein), as R.1976 d.329.
See: 8 N.J.R. 336(a), 8 N.J.R. 517(a).

11:4–11.1 Authority

This rule is adopted and promulgated by the Commissioner of Insurance pursuant to N.J.S.A. 17B:30–1 et seq. (Unfair and Deceptive Acts and Practices in the Business of Insurance Act).

11:4–11.2 Purpose

(a) The purpose of this regulation is to require insurers to deliver to purchasers of life insurance, information which will improve the buyer's ability to select the most appropriate plan of life insurance for his needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

(b) This regulation does not prohibit the use of additional material which is not in violation of this regulation or any other New Jersey statute or regulation.

11:4–11.3 Scope

(a) Except as hereafter exempted, this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this State. This regulation shall apply to any issuer of life insurance contracts.

(b) Unless otherwise specifically included, this regulation shall not apply to:

1. Annuities;
2. Credit life insurance;
3. Group life insurance;
4. Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA);
5. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

11:4–11.4 Definitions

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

"Buyer's guide" means a document which contains, and is limited to, the language contained in this appendix to this subchapter or language approved by the Commissioner of Insurance.

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

"Equivalent level annual dividend" means that amount which is calculated by applying the following steps:

1. Accumulate the annual cash dividends at five per cent interest compounded annually to the end of the tenth and 20th policy years;
2. Divide each accumulation of step 1 by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in step 1 over the respective periods stipulated in step 1. If the period is ten years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;
3. Divide the results of step 2 by the number of thousands of the equivalent level death benefit to arrive at the equivalent level annual dividend.

"Equivalent level death benefit of a policy or term life insurance rider" means an amount calculated as follows:

1. Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for ten and 20 years at five per cent interest compounded annually to the end of the tenth and 20th policy years respectively;
2. Divide each accumulation of step 1 above by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in step 1 over the respective periods stipulated in step 1. If the period is ten years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;

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

"Life insurance cost indexes" means the following:

1. "Life insurance surrender cost index" is calculated by applying the following steps:
   i. Determine the guaranteed cash surrender value, if any, available at the end of the tenth and 20th policy years;
   ii. For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual cash dividends at five per cent interest compounded annually to the end of the period selected and add this sum to the amount determined in subparagraph i of this paragraph;
   iii. Divide the result obtained in subparagraph ii above (subparagraph i for guaranteed-cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subparagraph ii (subparagraph i for guaranteed-cost policies) over the respective periods stipulated in subparagraph i. If the period is ten years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;
   iv. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at five per cent interest compounded annually to the end of the period stipulated in subparagraph i and dividing the result by the respective factors stated in subparagraph iii (this amount is the annual premium payable for a level premium plan);

v. Subtract the result of subparagraph iii from subparagraph iv;

vi. Divide the result of subparagraph v by the number of thousands of the equivalent level death benefit to arrive at the life insurance surrender cost index.

2. "Life insurance net payment cost index" is calculated in the same manner as the comparable life insurance cost index except that the cash surrender value and any terminal dividend are set at zero.

"Policy summary", for the purposes of these rules, means a written statement describing the elements of the policy, including but not limited to:

1. A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION;

2. The name and address of the insurance agent, or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary;

3. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written;

4. The generic name of the basic policy and each rider;

5. The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including, but not necessarily limited to, the years for which life insurance cost indexes are displayed and at least one age from 60 through 65 or maturity whichever is earlier:

i. The annual premium for the basic policy;

ii. The annual premium for each optional rider;

iii. Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide, or other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;

iv. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;

v. Cash dividends payable at the end of the year with value shown separately for the basic policy and each rider (Dividends need not be displayed beyond the 20th policy year);

vi. Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above;

6. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the policy summary includes the maximum annual percentage rate;

7. Life insurance cost indexes for ten and 20 years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders, which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits, nor for basic policies or optional riders covering more than one life;

8. The equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance costs indexes are displayed;

9. A policy summary which includes dividends shall also include a statement that dividends are based on the company's current dividend scale and are not guaranteed, in addition to a statement in close proximity to the equivalent level annual dividend as follows: An explanation of the intended use of the equivalent level annual dividend is included in the life insurance buyer's guide;

10. A statement in close proximity to the life insurance cost indexes as follows: An explanation of the intended use of these indexes is provided in the life insurance buyer's guide;

11. The date on which the policy summary is prepared.

Note: The policy summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as to not minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in paragraph 5 of this subsection shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

11:4–11.5 Disclosure requirements

(a) The insurer shall provide, to all prospective purchasers, a buyer's guide and a policy summary at least seven days prior to accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the policy summary contains such an unconditional refund offer, in which event the buyer's guide and policy summary must be delivered with the policy or prior to delivery of the policy.

(b) The insurer shall provide a buyer's guide and a policy summary to any prospective purchaser upon request.

(c) In the case of policies whose equivalent level death benefit does not exceed $5,000, the requirement for providing a policy summary will be satisfied by delivery of a written statement containing the information described in N.J.A.C. 11:4–11.4(g)2 through 7, 10 and 11.

(d) In the case of policies whose equivalent level death benefit is less than $2,000, the provision of a policy summary and a buyer's guide will be optional for the insurer.

(e) For in-force premium-paying policies, policy holders shall have the right to obtain a Policy Summary at cost. The company may charge a reasonable fee for preparing this summary, not to exceed $5.00, and may utilize reasonable assumptions in providing the cost disclosure information, so long as they are clearly disclosed. In calculating cost indexes on policy anniversaries 10 and 20 years from the date of request, the initial cash value, defined as the cash value of the policy (exclusive of policy loans and the value of dividend accumulations or dividend additions but including any terminal dividend) on the policy anniversary at the beginning of the period for which the indexes are calculated, should be reflected as follows:

1. The "equivalent level death benefit" defined in N.J.A.C. 11:4–11.4 is reduced by the amount of the initial cash value;

2. The "guaranteed cash surrender value" determined in N.J.A.C. 11:4–11.4 is reduced by the amount of the initial cash value; and

3. The "equivalent level premium" determined in N.J.A.C. 11:4–11.4 is increased by 4.7619 percent of the amount of the initial cash value.

As amended, R.1982 d.17, eff. February 1, 1982 (Operative June 1, 1982).
See: 13 N.J.R. 36(a), 14 N.J.R. 159(a).
(e) added.

11:4–11.6 General provisions

(a) Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to this regulation. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use.

(b) An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which he is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

(c) Terms such as estate planner, financial planner, investment advisor, financial consultant, or financial counseling shall not be used in such a way as to imply that the insurance agent is generally engaged in an advisory business in which compensation is unrelated to sale unless such is actually the case.

(d) Any reference to policy dividends must include a statement that dividends are not guaranteed.

(e) A system or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such a system may be used for the purpose of demonstrating the cash-flow pattern of a policy if such presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.

(f) A presentation of benefits shall not display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately in close proximity thereto.

(g) A statement regarding the use of the life insurance cost indexes shall include an explanation to the effect that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

(h) A life insurance cost index which reflects dividends or an equivalent level annual dividend shall be accompanied by a statement that it is based on the company's current dividend scale and is not guaranteed.

(i) For the purposes of this regulation, the annual premium for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

(j) All sales proposals and sales presentations of individual life insurance products which fail to fully and fairly inform an applicant or prospective insured as to future premium changes, benefits and related options constitute a misrepresentation as to material facts.

(k) With respect to life insurance products which require an additional first year premium, for which there are no comparable additional first year insurance benefits, and which also contain partial endowment benefits or their cash value equivalent, any statement or illustration in any advertisement, sales material, or sales presentation which uses such terms as "deposit," "accumulation," "interest at x percent," "double your money" and similar terms associated with fund accumulations and investment contracts is prohibited unless the insurer can demonstrate that all major characteristics customarily associated with such contracts are present; the name given to such products shall not include any term that implies a "deposit" or any similar term; and no statement may be made or implied which purports to

show that the partial endowment or cash value equivalent arises solely from the additional first year premium.

(*l*) If the policy contains a provision permitting the making of voluntary deposits which will accumulate at interest, the nature thereof shall be disclosed, and such disclosure shall distinguish such deposit provision and the insured's rights thereunder from any other premiums for the basic policy and riders.

As amended, R.1982 d.17, eff. September 1, 1982 (Operative June 1, 1982).
See: 13 N.J.R. 36(a), 14 N.J.R. 159(a).
(j), (k) and (*l*) added.

11:4–11.7 Failure to comply

Failure of an insurer to provide or deliver a buyer's guide or a policy summary as provided in N.J.A.C. 11:4–11.5, shall constitute an omission which misrepresents the benefits, advantages, conditions or terms of an insurance policy.

11:4–11.8 Effective date

With respect to the buyer's guide, this rule shall apply to all solicitations of life insurance which commence on or after February 1, 1977; otherwise, this rule shall apply to all solicitations of life insurance which commence on or after January 1, 1978.

As amended, R.1977 d.187, eff. May 25, 1977.
See: 9 N.J.R. 283(a).

APPENDIX

LIFE INSURANCE BUYER'S GUIDE

The face page of the buyer's guide shall read as follows:
LIFE INSURANCE BUYER'S GUIDE

This guide can show you how to save money when you shop for life insurance. It helps you to:

Decide how much life insurance you should buy;

Decide what kind of life insurance policy you need; and

Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (company name)
(month and year of printing)

The buyer's guide shall contain the following language at the bottom of page 2:

The National Association of Insurance Commissioners is an association of State insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this guide in making a life insurance purchase.

THIS GUIDE DOES NOT ENDORSE ANY COMPANY OR POLICY.

The remaining text of the buyer's guide shall begin on page 3 as follows:

BUYING LIFE INSURANCE

When you buy life insurance, you want a policy which fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes which are described in this guide. A good life insurance agent or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand which kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance agent or company or books on life insurance in your public library.

CHOOSING THE AMOUNT

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

CHOOSING THE RIGHT KIND

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance:

1. Term insurance;
2. Whole life insurance;
3. Endowment insurance.

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the agent or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term Insurance: Term insurance is death protection for a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible". This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premium for the new policy will be higher than you have been paying for the term insurance.

Whole Life Insurance: Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premium for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your late years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits". This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash value may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money which you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance: An endowment insurance policy pays a sum or income to you, the policyholder, if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than for the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

FINDING A LOW COST POLICY

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "surrender cost index" and the other is the "net payment cost index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What is Cost?: "Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "nonparticipating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What are Cost Indexes?: In order to compare the cost of policies, you need to look at:

1. Premiums;
2. Cash values;
3. Dividends.

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies.

When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies:

1. LIFE INSURANCE SURRENDER COST INDEX—This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare cost if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value;

2. LIFE INSURANCE NET PAYMENT COST INDEX—This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the equivalent level annual dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's equivalent level annual dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a nonparticipating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the nonparticipating policy will not change.

How Do I Use Cost Indexes?: The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a large index number. The following rules are also important:

1. Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be;

2. Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a "shopper's guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys;

3. Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost;

4. In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder;

5. These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for a while, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

IMPORTANT THINGS TO REMEMBER—A SUMMARY

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums most closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare surrender cost indexes and net payment cost indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance agent can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you can make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the agent or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

SUBCHAPTER 12. STUDENT LIFE INSURANCE

11:4-12.1 Student life insurance solicitation

(a) The purpose is to avoid any link or implication of association between a school or university and an insurance company soliciting life insurance unless specific endorsement by the school has been made.

(b) Student life insurance is life insurance offered to a person because he/she is enrolled in an institution offering a post high school education.

(c) Requirements governing the envelope in which a solicitation is mailed, delivered or offered are as follows.

1. A return address must appear in the front upper left corner of the envelope and must provide the full name and street address of the company, agent or broker soliciting the insurance, who must be identified as such. Example of a suitable return address is: Ann Doe, Insurance Agent, 00 Main Street, Chester, New Jersey 08001.

2. The return address may not use the term "office of".

3. The envelope may be addressed to "The Parents of Joan Smith" or to specifically named parents, that is, "Mr. & Mrs. Smith". The address may not include any combination of words that indicates that the correspondence is coming from the school itself rather than the insurance company or agent, nor may it imply that the school has endorsed the material and supplied the company with information about the student. Examples of unacceptable modes of address include, but are not limited to, the following:

i. "The Parents of Registered Freshman Joan Smith";

ii. "The Parents of Cornell University Student Joan Smith";

iii. "The Parents of Joan Smith, Yale Sophomore";

iv. "Tom Jones, Yale Senior".

4. If the term "Student Insurance Forms Enclosed" is used on the envelope, it must appear on one continuous line. For example, it is impermissible to divide the words so that "student insurance" appears on one line and "forms enclosed" on the next.

5. The slogan which often appears on an envelope to the left of the postal meter stamp may not focus on or mention education. Neutral slogans, such as "Buy Government Bonds" or "Support Your Local United Fund", are acceptable.

(d) Requirements governing all solicitation materials, including letters, circulars and informational flyers are as follows.

1. All material must be clearly identified as coming from an agent, broker or company, if such is the case, and these entities must be clearly identified as such.

i. Names and addresses of the soliciting agent, broker and company must appear at the top of the first page of the letter or brochure in print size no smaller than 14–point type.

ii. Logos may not be substituted for the information required above.

2. No connection between the school and the insurance company, agent or broker is to be implied unless the school has specifically endorsed the policy being sold.

3. "Office of" is prohibited from use anywhere on the materials.

4. The salutation and inside address on the solicitation material may be addressed to "The Parents of Joan Smith" or to the specifically named parents, that is, "Mr. & Mrs. Smith". The inside address may not include any combination of words that indicate that the correspondence is coming from the school itself rather than the insurance company or agent, nor may it imply that the school has endorsed the material and supplied the company with information about the student. Examples of inappropriate modes of address include, but are not limited to, the following:

i. "The Parents of Registered Freshman Joan Smith";

ii. "The Parents of Cornell University Student Joan Smith";

iii. "The Parents of Joan Smith, Yale Sophomore";

iv. "Tom Jones, Yale Senior".

(e) Records required to be maintained include the following.

1. Complete sample mailings must be on file at the home office of the insurer for a period of five years subsequent to the date of the mailings.

2. The soliciting New Jersey agent or broker must keep the same records on file as the insurer.

3. The above files shall include:

i. Description of target groups solicited;

ii. Specimen copy of mailing;

iii. Date of mailing and number of pieces mailed.

R.1977 d.254, eff. November 1, 1977.
See: 9 N.J.R. 280(a), 9 N.J.R. 372(a).

SUBCHAPTER 13. GROUP STUDENT HEALTH INSURANCE

Authority

Unless otherwise expressly noted, all provisions of this subchapter were adopted pursuant to authority of N.J.S.A. 17:1–8.1, 17:1C–6(e) and 17B:27–49, and were filed and became effective on August 22, 1977, as R.1977 d.309. See: 9 N.J.R. 343(c), 9 N.J.R. 438(d).

11:4–13.1 Scope

(a) This rule prohibits certain provisions of group student health insurance policies and certificates which are unjust, unfair, inequitable, misleading, contrary to law or contrary to public policy of this State.

(b) The rule shall apply to all student health insurance policies or subscriber contracts delivered or issued for delivery after January 1, 1978.

(c) The group student health insurance continues to be subject to subchapter 13, the group coverage discontinuance and replacement rules.

11:4–13.2 Definitions

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

"Group student health insurance" is any general coverage accident and/or sickness insurance provided on a group basis to the students of a school.

"Mandatory" refers to a requirement that all students, or all students who are not already insured for the same or similar benefits under other coverages, must purchase the insurance or are billed for the coverage and must return a waiver form to obtain exemption from payment.

"Optional" means that the students may elect to purchase or to reject the insurance and are not requested to return a waiver form in order to be exempt from payment.

11:4–13.3 Prohibited provisions

(a) Rules concerning preexisting conditions are as follows.

1. Mandatory coverage: If the group student health insurance is mandatory, preexisting conditions shall not be excluded from coverage.

2. Optional coverage: When the group student health insurance is optional, the carrier may exclude conditions which existed prior to the effective date of coverage and for which the student received medical advice or treatment within a period of up to six months prior to the date the loss is incurred. Such a preexisting condition exclusion can only be applicable during the initial period of the student's coverage under the school's program.

3. Both mandatory and optional coverage:

i. Losses which commence before the effective date of the first year of coverage may be excluded;

ii. Treatment for accidental bodily injury which occurred before the effective date of the first year of coverage may be excluded unless the injury is indivisible from an accidental injury occurring during coverage.

SUBCHAPTER 14. HOME HEALTH CARE INSURANCE COVERAGE

Authority

Unless otherwise expressly noted, all provisions of this subchapter were adopted pursuant to authority of N.J.S.A. 17:1–8.1, 17:1C–6(e) and c.98 and 99, L.1977, and were filed and became effective on December 15, 1977, as R.1977 d.476. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

11:4–14.1 Scope

These rules apply to individual and group health insurance policies which provide coverage for the costs of daily room and board while confined in a hospital or skilled nursing facility. They do not apply to hospital indemnity policies which provide additional income while the insured is hospitalized. These rules also do not apply to Medicare complement policies since Medicare provides home health care.

11:4–14.2 Definitions

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

"Home health care" means those nursing and other home health care services rendered to a person in his place of residence, under the following conditions:

1. On a part-time and intermittent basis, except when full-time or 24–hour services are needed on a short-term (no more than three-day) basis; and

2. If continuing hospitalization would otherwise have been required if home health care were not provided; and

3. Pursuant to a physician's written order and under a plan of care established by the responsible physician in collaboration with a home health care provider. The benefit may require that the care plan be reviewed by the physician after each 30 days following commencement of home health care, that the physician not be related to the home health care provider by ownership or contract, and that the physician certify that continued confinement in a hospital or skilled nursing facility would otherwise be required. All care plans shall be established within 14 days following the commencement of home health care.

"Home health care services" means any of the following services which are medically necessary for achievement of the care plan set forth for the patient and which are provided for the care of the patient:

1. Nursing care (furnished by or under the supervision of a registered nurse);

2. Physical therapy;

3. Occupational therapy;

4. Medical social work;

5. Nutrition services;

6. Speech therapy;

7. Home health aide services;

8. Medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under the policy if the covered person had remained in a hospital;

9. Any diagnostic and therapeutic service, including surgical services, performed in a hospital outpatient department, a doctor's office or any other licensed health care facility, to the extent that such service would have been covered under the policy if performed as inpatient hospital services, provided that such service is delivered as part of the home health care plan.

"Home health care provider" means an agency which is licensed by the Commissioner of the Health as a home health agency.

11:4–14.3 Home health care benefits required

(a) Minimum coverage rules are as follows:

1. The policy may require no more than three continuous days of hospitalization or skilled nursing facility care prior to provision of home health care benefits.

2. The home health care services listed in paragraphs 1 through 7 of the definition of home health care services must provide for at least 60 home health care visits in any calendar year or in any continuous period of 12 months.

3. Any visit by a member of a home health care team on any day shall be considered as one home health care visit.

4. If the policy contains a number of days during which home health care benefits must commence following hospital discharge, that number of days may not be less than three.

5. The services and supplies listed in paragraphs 1 through 8 of the definition of home health care services shall be furnished by a home health care provider and the charges for such services and supplies shall be made by the home health care provider.

(b) Extent of payment rules are as follows:

1. The dollar amount of payment for all home health care visits on each of the first three days of home health care services need not exceed the daily hospital room and board benefit provided by the policy during the period of prior confinement. The dollar amount of payment for all home health care visits on each subsequent day of home health care services need not exceed one half the daily hospital room and board benefit provided by the policy during the period of prior confinement. For policies which provide only benefits for skilled nursing facility care, the dollar amount of payment for each home health care visit need not exceed the daily skilled nursing facility room and board benefit.

2. Charges for home health care services may be limited to the usual and customary charges for such services.

(c) Compliance with the home health care law concerning direct reimbursement will be met if the policy includes the direct payment provisions of N.J.S.A. 17B:26–12b or 17B:27–45, or if an assignment of benefits is made available to the insured. It is not intended that the insured be denied the right to receive benefit payments which is provided by the statute.

11:4–14.4 Exclusions

(a) This subchapter does not impose an obligation to pay benefits for physician's services in connection with home health care except for those benefits required under paragraph 9 of the definition of home health care services.

(b) Home health care services including those of home health aides need not be reimbursable to the extent they have been provided for persons in the household other than the patient.

(c) Policy exclusions relating to worker's compensation, employer's liability laws, Medicare, mandatory no-fault automobile insurance, veteran's hospitals, military service, and so forth, applicable to hospital and skilled nursing facility confinement benefits may also apply to home health care benefits.

(d) Benefits need not be payable if no charge is normally made for a home health care service.

(e) Policy provisions relating to coordination of benefits may apply to home health care services to the same extent that they apply to other benefits provided by the policy.

(f) The policy may require that home health care services will be provided only to residents of New Jersey.

11:4–14.5 Effective date

These rules shall be effective on December 15, 1977.

SUBCHAPTER 15. ALCOHOLISM BENEFITS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17B:27–46.1 and 17B:26–2.1.

Source and Effective Date

R.1986 d.228, effective June 16, 1986.
See: 18 N.J.R. 607(a), 18 N.J.R. 1302(a).

Subchapter Historical Note

All provisions of this subchapter became effective May 22, 1978 as R.1978 d.165. See: 10 N.J.R. 162(a), 10 N.J.R. 257(a). The subchapter expired pursuant to the sunset provisions of the Executive Order No. 66(1978) and New Rules became effective June 16, 1986 as R.1986 d.228. See: 18 N.J.R. 607(a), 18 N.J.R. 1302(a).

11:4–15.1 Scope

This subchapter applies to all individual and group health insurance policies providing hospital-medical expense benefits issued or renewed in this State. "Renewed" is defined as any date the insurer has the option to change the level of premium rates. This subchapter does not apply to policies which provide only limited hospital or medical expense coverage, such as: Medicare complement policies, hospital income policies, student accident, trip or accident only policies, PIP coverage, cancer or dread disease policies, or surgical expense policies, or to policies issued prior to June 2, 1977, where the premium is guaranteed at issue and the insurer cannot increase the premium.

11:4–15.2 Benefits

(A) The following benefits shall be included in each contract:

1. Where benefits are defined in terms of inpatient days, treatment of alcoholism by means of inpatient confinement in a detoxification facility or a residential treatment facility, and outpatient treatments shall be considered equivalent to inpatient hospital days and afforded the same kind of coverage under the policy as an alternative to inpatient hospital days.

2. For policies that provide blanket reimbursement for medical expenses, with or without deductibles, coinsurance, and inside limits, alcoholism shall be covered as any other sickness, subject to the same deductibles and coinsurance, but with the inside limits on inpatient hospital days applying equally to detoxification facilities, residential treatment facilities, and outpatient treatments.

3. Outpatient treatment is defined as treatment on an outpatient basis at a hospital or residential treatment facility or as aftercare at a detoxification facility as provided by certified alcoholism counselors and other professionals employed by these health care facilities under a program approved by the Division on Alcoholism.

11:4–15.3 Exclusions

(a) An insurer may avail itself of any appropriate legal methods to avoid duplication of coverage, such as coordination of benefits provisions or statutory provisions concerning other insurance.

(b) Alcoholism benefits must be included for all certificate holders under all group policies issued or renewed in New Jersey. New Jersey residents insured under group policies issued in other states are not covered by this role.

(c) Policy exclusions relating to workers' compensation, employers' liability laws, veterans' hospitals, military services, etc. may apply also to benefits for alcoholism treatment.

(d) Benefits need not be payable if no charge is normally made for the service.

(e) Benefits may be limited to the reasonable and customary charges for care and treatment.

(f) Benefits may be limited to expenses for treatment provided at the appropriate level of care.

SUBCHAPTER 16. MINIMUM STANDARDS FOR INDIVIDUAL HEALTH INSURANCE

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17B:22–1, 17B:26–1 et seq., 17B:26–44.6 and 17B:26–45.

Source and Effective Date

R.1985 d.221, effective April 15, 1985.
See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a).

Subchapter Historical Note

All provisions of this subchapter were filed and became effective on April 21, 1980, as R.1980 d.176. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c). On June 12, 1980 the Legislature adopted Senate Concurrent Resolution 110 disapproving this subchapter pursuant to N.J.S.A. 17B:26–45d. On August 5, 1980 the Department of Insurance readopted the subchapter in its entirety, with amendments to N.J.A.C. 11:4–16.8(b), as R.1980 d.343. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b). This subchapter was readopted pursuant to Executive Order No. 66(1978) effective April 15, 1985 as R.1985 d.221. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a). See chapter and section levels for further amendments.

11:4–16.1 Purpose

The purpose of this regulation is to implement Chapter 78 of the Laws of 1979 so as to provide reasonable standardization and simplification of language, terms and coverages to facilitate understanding and comparisons; elimination of provisions which may be misleading or unreasonably confusing in connection with either the purchase of insurance or the settlement of claims; elimination of provisions which may be contrary to the health care needs of the public; elimination of coverages which are so limited in scope as to be of no substantial economic value to the holders thereof; and elimination of unfair renewal practices which are contrary to the health care needs and economic well-being of the public.

11:4–16.2 Applicability and scope

This regulation shall apply to all individual health insurance policies delivered or issued for delivery in this State on or after the effective date hereof except that it shall not apply to conversion policies issued pursuant to a contractual conversion privilege or to credit health insurance. As used herein, policy means the entire contract between the insurer and the insured including all policies, certificates, riders, applications and endorsements which are required to be filed pursuant to N.J.S.A. 17B:26–1 and N.J.S.A. 17:44A–21. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted. Nothing in this regulation shall be construed to limit the commissioner's authority to disapprove policies pursuant to N.J.S.A. 17B:26–1h, which in the opinion of the commissioner contain provisions that are unjust, unfair, inequitable, misleading or contrary to law or public policy of this State.

11:4–16.3 Effective date

This regulation shall be effective after it has been accepted by the Legislature. Acceptance by the Legislature will occur 60 days after the regulation has been submitted to the Legislature, unless the Legislature passes a concurrent resolution stating in substance that the Legislature does not favor this regulation. This regulation shall be applicable to all individual health insurance policies, not specifically exempt from this regulation, delivered or issued for delivery in this State 120 days after acceptance by the Legislature.

11:4–16.4 Policy definitions

(a) Except as provided hereafter, no health insurance policy delivered or issued for delivery in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

1. "Accident", "accidental injury", "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 characteristics.

i. "Injury" shall not be defined more restrictively than accidental bodily injury sustained by the insured person which is the direct cause of the loss, independent of disease, bodily infirmity or other cause, and which occurs while the insurance is in force.

(1) Such definition may provide that injuries shall not include injuries for which benefits are provided under workers' compensation, employer's liability or similar law, out-of-State automobile insurance coverage as defined at N.J.A.C. 11:3–37.2 and provided for at N.J.A.C. 11:3–37.3, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

2. "Sickness" shall not be defined more restrictively than a sickness or disease which causes loss commencing while the policy is in force and which is not excluded under a preexisting condition limitation. A definition may provide for a probationary period which will not exceed 30 days from the effective date of the coverage of an insured person. Such probationary period shall not apply to newly-born children where immediate coverage is required by N.J.S.A. 17B:26–2. The definition may also be modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

3. "Preexisting condition" shall not be defined to be more restrictive than subparagraphs i and ii as stated below. Subparagraph i shall apply where the insurer uses an application form designed to elicit the complete health history of a prospective insured and, on the basis of the answers on that application, underwrites in accordance with the insurer's established standards. Subparagraph ii shall apply where the insurer elects to use a simplified application, with or without a question as to the applicant's health at the time of application, or elects not to use any application.

i. A condition misrepresented or not revealed in the application and for which symptoms existed prior to the effective date of coverage that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice or treatment was recommended by or received from a physician.

ii. A condition for which symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a one year period preceding the effective date of the coverage or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a five year period preceding the effective date of the coverage.

4. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

i. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(1) Be an institution operated pursuant to law; and

(2) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff or duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

(3) Provide 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

ii. The definition of the term "hospital" may state that such term shall not be inclusive of:

(1) Convalescent homes, convalescent, rest, or nursing facilities;

(2) Facilities primarily affording custodial, educational or rehabilitative care;

(3) Facilities for the aged or drug addicts; or

(4) Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

5. "Convalescent nursing home", "extended care facility", or "skilled nursing facility" shall be defined in relation to its status, facilities, and available services.

i. A definition of such home or facility shall not be more restrictive than one requiring that it:

(1) Be operated pursuant to law;

(2) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(3) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(4) Provide continuous 24 hour a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

(5) Maintain a daily medical record of each patient.

ii. The definition of such home or facility may provide that such term shall not be inclusive of:

(1) Any home, facility or part thereof used primarily for rest;

(2) A home or facility for the aged or for the care of drug addicts; or

(3) A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

6. "One period of confinement" means consecutive days of in-hospital service received as an inpatient, or successive confinements due to the same or related causes, when discharge from and readmission to the hospital occurs within a period of time not more than 90 days or not more than three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

7. "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician". The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

8. "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse", "trained nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the Board of Nursing or any other registry board of the State.

9. "Total disability" shall not be defined more restrictively during the first year of disability in a policy that provides disability income benefits than the inability of the insured to engage in his own occupation. During any other period of disability, total disability shall not be defined more restrictively than the complete inability of the insured to engage in any employment or occupation for which the insured is qualified by reason of education, training or experience. Total disability need not be deemed to exist if the insured is actually engaged in any employment or occupation for wage or profit.

i. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

(1) Perform "any occupation whatsoever", "any occupational duty", or "any and every duty of his occupation" or;

(2) Engage in any training or rehabilitation program.

ii. An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured's immediate family).

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

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

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

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

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

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

16. "Noncancellable insurance" or "noncancellable and guaranteed renewable insurance" means all individual insurance which gives the insured the right to continue the insurance in force by the timely payment of premiums set forth in the policy until at least age 50, or in the case of a policy issued after age 44 for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while it is in force.

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

i. Fraud in applying for the policy;

ii. Fraud in the submission of claims;

iii. Duplication of benefits or overinsurance in accordance with insurer's standards;

iv. Attainment of a specified age;

v. Discontinuance of all policies issued on the same form in this State;

vi. In policies issued to employees of an employer or to members of an association:

(1) Termination of employment or membership;

(2) Discontinuance of all policies issued on the same form to employees of the employer or to members of the association.

vii. Change of the insured's occupation to an occupation classified as more hazardous than the original occupation;

viii. Other reasons for nonrenewal which are appropriate to the coverage may be used if they are approved by the commissioner.

Emergency Amendment, R.1990 d.625, effective November 26, 1990 (expires January 25, 1991).
See: 22 N.J.R. 3777(a).
Amended to effectuate the purpose and intent of Section 6 of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8 ("FAIR Act"), which becomes operative January 1, 1991.
Adopted Concurrent Proposal, R.1991 d.90, effective January 25, 1991.
See: 22 N.J.R. 3777(a), 23 N.J.R. 597(a).
Provisions of emergency amendment R.1990 d.625 readopted without change.

11:4–16.5 Prohibited policy provisions

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

(b) No policy except a short term, nonrenewable trip policy shall provide coverage solely for specifically identified kind(s) of accident(s); however a policy may provide in-

creased benefits for specifically identified accident(s) for any accident only coverage specified in section 6(g) of this subchapter.

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

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

(e) A limited benefit health policy which provides only social insurance benefits (insurance which pays benefits when government mandated program benefits are not payable) may be issued if it meets the conditions stated in section 6(e)3 of this subchapter.

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

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

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

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

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

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

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

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

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

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

1. Preexisting conditions other than congenital anomalies of a covered newborn dependent child;

2. Mental or emotional disorders and drug addiction;

3. Normal pregnancy and childbirth;

4. Illness, treatment or medical condition arising out of:

i. War or act of war (whether declared or undeclared), participation in a riot or insurrection, service in the armed forces or units auxiliary thereto;

ii. Suicide (while sane or insane), attempted suicide or intentionally self-inflicted injury;

iii. Aviation, other than as a fare paying passenger on a regularly scheduled airline;

iv. With respect to short-term nonrenewable policies, interscholastic sports.

5. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered newborn dependent child which has resulted in a functional defect;

6. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

7. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

8. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, out-of-State automobile insurance coverage as defined at N.J.A.C. 11:3–37.2 and provided for at N.J.A.C. 11:3–37.3; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

9. Dental care or treatment;

10. Eye glasses, hearing aids and examination for the prescription or fitting thereof;

11. Rest cures, custodial care, transportation and routine physical examinations;

12. Territorial limitations.

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

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

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

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

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

Emergency Amendment, R.1990 d.625, effective November 26, 1990 (expires January 25, 1991).
See: 22 N.J.R. 3777(a).
Amended to effectuate the purpose and intent of Section 6 of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8 ("FAIR Act"), which becomes operative January 1, 1991.
Adopted Concurrent Proposal, R.1991 d.90, effective January 25, 1991.
See: 22 N.J.R. 3777(a), 23 N.J.R. 597(a).
Provisions of emergency amendment R.1990 d.625 readopted without change.

11:4–16.6 Minimum standards for benefits

(a) The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual health insurance policy shall be delivered or issued for delivery in this State which does not meet the required minimum standards for the specified categories unless the Commissioner finds that such policies can be filed as a limited benefit health coverage and the outline of coverage complies with the appropriate outline in N.J.A.C. 11:4–16.8.

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

(c) General rules include the following:

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

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

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

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

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

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

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

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

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

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

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

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

iv. If the policy requires the insured to pay for any part of the second surgical opinion (copayment, deductible, maximum amount), the premium for the policy cannot exceed the premium payable for a comparable policy without second surgical opinion benefits, and the insurer shall disclose to the insured that his out-of-pocket expenses may exceed the expenses which would result from an otherwise comparable policy without a second surgical opinion benefit. See section 8(d), (e), and (f) of this subchapter for disclosure requirements.

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

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

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

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

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

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

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

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

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

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

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

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

ii. Any underwriting requirements that must be satisfied in order to exercise the option (income limits, health status, other insurance) must be specified in the option. The option may not state that no evidence of insurability is required, if such underwriting criteria are imposed.

iii. The time limit on certain defenses for the additional insurance shall run from the date of the original policy for the duration specified in the original policy, except that such time limit may run from the effective date of the additional insurance for any representations material to the issue of new insurance.

iv. Prior to each option date, the insurer shall notify the insured of the availability of the additional insurance. Such notice shall be given in sufficient time to exercise the option.

v. Guaranteed insurability options may only provide for additional coverage, without evidence of insurability, of a kind directly comparable to the kind of coverage provided by the basic policy to which the option is attached.

21. Policies which reduce benefits at a specified age shall only be issued at ages which provide full coverage for at least five years. This rule shall not apply to hospital-medical expense benefits or hospital indemnity benefits which are reduced at the Medicare eligible age nor to disability income benefits where the basis for the reduction is retirement at 65 or a later age.

22. Termination of the policy shall be without prejudice to any claim for continuous loss which commenced while the policy was in force; however, the payment of benefits after the termination date may be predicated upon the continuous disability of the insured, limited to the duration of the benefit period or payment of the maximum benefits.

(d) "Basic hospital expense coverage" is a health insurance policy which provides coverage for a period of not less than 31 days for one period of hospital confinement of each covered person for expenses incurred for necessary treatment and services rendered as a result of injury or sickness for at least the following:

1. Daily hospital room and board, including general nursing care and special diets, in an amount not less than the lesser of:

i. 80 percent of the charges for semi-private accommodations; or

ii. The Statewide average semi-private hospital room and board charge at the time the policy is issued, as determined by the New Jersey Department of Health.

2. Miscellaneous hospital services, for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than 80 percent of the charges incurred up to at least $1800 or 10 times the daily hospital room and board benefits; and

3. Hospital outpatient services, consisting of:

i. Hospital services on the day surgery is performed;

ii. Hospital services rendered within 72 hours after accidental injury, in an amount not less than $50; and

iii. X-ray and laboratory tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital, in an amount not less than $100.

4. Benefits provided under (d)1 and 2 above may be provided subject to a combined deductible amount not in excess of $100.00.

(e) "Basic medical-surgical expense coverage" is a health insurance policy which provides coverage for each covered person for expenses incurred for the necessary services rendered by a physician for treatment of injury or sickness for at least the following:

1. Surgical services in an amount not less than:

i. 80 percent of the reasonable charges; or

ii. Those based on a relative value fee schedule with a maximum of at least $500 for the most severe procedure. Acceptable relative value fee schedules include, but are not limited to, the New York certified surgical fee schedule or the 1964 California Relative Value Schedule.

2. Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical services rendered by a physician other than the physician (or his assistant) performing the surgical services in an amount not less than:

i. 80 percent of the reasonable charges; or

ii. 15 percent of the surgical service benefit.

3. In-hospital services, consisting of physicians' services rendered to a person who is hospital confined, for treatment of injury or sickness other than that for which surgical care is required, in an amount not less than:

i. 80 percent of the reasonable charges; or

ii. One percent of the maximum surgical fee for each day for not less than 21 days during one period of confinement.

(f) Major medical expense coverage includes:

1. "Major medical expense coverage" is a health insurance policy which provides hospital, medical and surgical expense coverage for each covered person to a maximum of not less than $10,000; copayment by the covered person not to exceed 25 percent of covered charges; a deductible stated on a per person, per family, per illness, per benefit period or per year basis or combination of such bases, not to exceed five percent of the maximum limit under the policy. The policy shall provide at least the following benefits for each covered person after application of the copayment percentage.

i. Daily hospital room and board expenses as defined in (b)1 above for a period of not less than 31 days during one period of hospital confinement;

ii. Miscellaneous hospital services for a maximum of not less than $1800 or 15 times the daily room and board rate if specified in dollar amounts during one period of hospital confinement;

iii. Surgical services to a maximum of not less than $600.00 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

iv. Anesthesia services for a maximum of not less than 15 percent of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

v. In-hospital medical services as defined in (e)3 above;

vi. Out-of-hospital care consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician;

vii. Prosthetic appliances, meaning artificial limbs or other prosthetic appliances (except replacements thereof);

viii. Casts, splints, trusses, or braces; and

ix. Not fewer than three of the following additional benefits for a maximum of such covered charges of not less than $1000:

(1) In-hospital private duty graduate registered nurse services;

(2) Convalescent nursing home care;

(3) Diagnosis and treatment by a radiologist or physiotherapist;

(4) Rental or special medical equipment, as defined by the insurer in the policy;

(5) Treatment for functional nervous disorders, and mental and emotional disorders; and

(6) Out-of-hospital prescription drugs and medications.

2. Alternatively, "major medical expense coverage" is a health insurance policy which provides hospital, medical and surgical expense coverage for each covered person to a maximum of not less than $25,000; copayment by the covered person not to exceed 25 percent of covered charges; a variable deductible on a per person, per family, per illness, per benefit period or per year basis or a combination of such bases, for at least the amounts described in (f)1i through ix above and which meets the following conditions:

i. The deductible is defined as the greater of a minimum deductible of not less than $1500 or the amount of other medical expense coverage.

ii. The amount of covered expenses required to be incurred during a claim qualification period cannot exceed the minimum deductible.

iii. The policy includes a provision allowing the insured to change the amount of the Minimum Deductible under stated conditions as to evidence of insurability, notice and effective date.

iv. An annual notice is sent to New Jersey insureds advising them of their right to change the Minimum Deductible if their circumstances have changed.

v. If the minimum deductible exceeds $10,000, the benefit period does not begin until covered expenses exceed the deductible.

vi. If the minimum deductible exceeds $10,000, the claim qualification period is not less than 18 months.

(g) Disability income protection coverage includes:

1. "Disability income protection coverage" is a health insurance policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

i. "Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50 percent of amounts payable immediately prior to 62;

ii. Contains an elimination period no greater than:

(1) 90 days in the case of coverage providing a benefit of one year or less;

(2) 180 days in the case of coverage providing a benefit of more than one year but not greater than two years; or

(3) 365 days in all other cases during the continuance of disability resulting from sickness or injury;

iii. If a policy contains an elimination period in excess of six months, provides a premium waiver disability benefit which becomes operative not later than six months after commencement of total disability regardless of whether or not income indemnity is then payable, or provides for full reinstatement without evidence of insurability during a continuous period of total disability if the policy has lapsed after the sixth month of the elimination period;

iv. Has a maximum period of time for which benefits are payable during disability of at least six months except in the case of a policy covering disability arising out of normal pregnancy or childbirth in which case the period for such disability may be one month;

v. If the policy terminates benefits at a specified age, provides a minimum benefit period of at least one year or the length of the benefit period if less than one year;

vi. Where a policy provides that periodic payments are reduced if the insured is not gainfully employed away from the home, provides a benefit which is at least 50 percent of the full periodic payment and for return of the pro rata unearned premium for the period the insured is not so employed.

Note: This subsection 1 does not apply to business buyout coverage.

2. A cash value or premium refund benefit may be included in disability income protection coverage if the following conditions are met:

i. The insurer must submit copies of sales or advertising literature and a statement of the class or type of insureds to whom the policy will be sold;

ii. The benefit is only included in a policy which is noncancellable or guaranteed renewable;

iii. The benefit payable is not reduced by an amount greater than the aggregate of claims paid under the policy;

iv. If the cash value or premium refund benefit depends on the policy being in force for a given term, and if the insured dies or otherwise terminates coverage prior to the end of the term, an appropriate benefit is provided. The benefit should be related to the number of years the cash value of premium refund provision has been in force and to the cash value or premium refund which would have been provided at the end of the given term. Some variation by issue age may be allowed.

3. A social insurance benefit may be included in disability income protection coverage if the following conditions are met:

i. Social insurance benefit is defined as a disability income benefit which is payable when the insured is not receiving disability benefits under government mandated programs including, but not limited to, Federal Social Security, Workers' compensation or occupational disability laws, automobile no-fault insurance;

ii. The amount payable for total disability is a fixed dollar amount;

iii. The insurer submits to the department the under-writing rules and benefit limits applicable to the benefit and any promotional material that will be presented to the proposed insured;

iv. Experience on policies that include the benefit is kept and reported separately from policies without the benefit.

(h) "Hospital confinement indemnity coverage" is a health insurance policy which provides daily benefits on an indemnity basis for a period of not less than 31 days during one period of hospital confinement for each person covered under the policy and which:

1. Provides a daily benefit of not less than $40; and

2. Contains no elimination period greater than three days.

(i) "Accident only coverage" is a health insurance policy which provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least $1,000 and a single dismemberment amount shall be at least $500.

(j) "Medicare supplement coverage" is a health insurance policy sold to a Medicare eligible person, which is designed primarily to supplement Medicare, or is advertised, marketed, or otherwise purported to be a supplement to Medicare and which meets the minimum benefit standards and other requirements set forth in N.J.A.C. 11:4–23.

(k) "Limited benefit health coverage" is any health insurance policy which provides benefits that are less than the minimum standards for benefits required under N.J.A.C. 11:4–16.6(d), (e), (f), (g), (h), (i) and (j). Such policies may be delivered or issued for delivery in this State only if the outline of coverage required by N.J.A.C. 11:4–16.8(m) or (n) is completed and delivered as required by N.J.A.C. 11:4–16.8(b).

Amended by R.1988 d.453, effective September 19, 1988.
See: 20 N.J.R. 172(a), 20 N.J.R. 2377(b).
Deleted text from (d)1ii and inserted new.
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).
Subsection (j) 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 (J)3.viii.: revised internal citations and references.
Amended by R.1991 d.345, effective July 1, 1991.
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).
Added reference to "Medicare supplement policies" in (c)1.
Added "other requirements set forth in N.J.A.C. 11:4–23," in (j).
Deleted (j)1, 2, 3.

11:4–16.7 Application forms

(a) Application forms shall not include provisions, statements or questions that:

1. Pertain to race, creed, color, national origin or ancestry of the proposed insured;

2. Change the terms of the policy to which it is attached;

3. State that the applicant has not withheld any information or concealed any facts; or

4. Require the applicant to agree that an untrue or false answer material to the risk shall render the contract void.

(b) If the insurer makes any changes or amendments to the application, signed acceptance by the applicant is required.

(c) Factual-type questions shall be used whenever possible to ascertain the past and present health of a proposed insured. If opinion-type questions are used, the application shall provide that the answers are stated to the best of the applicant's knowledge and belief.

(d) Questions concerning alcohol and drug abuse shall be based on specific criteria such as treatment, driving records, work attendance records, etc. Questions such as "Do you use alcohol or drugs to excess" shall not be used.

(e) Application forms shall include a means for identifying the coverage or policy for which application is made.

11:4–16.8 Required disclosure provisions

(a) General disclosure requirements are as follows:

1. Each individual policy of health insurance shall include a renewal, continuation, or nonrenewal provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

2. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder, exercises a specifically reserved right under the policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term, shall be agreed to in a written instrument signed by the insured, except if the increased benefits or coverage is required by law.

3. Where riders or endorsements which reduce or eliminate coverage are attached to the policy at issue, the policy shall contain on the first page or specification page either a prominent warning or the full text of the rider or endorsement.

4. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

5. The words "guaranteed renewable" shall not be used in a policy unless the insurer's right to change premium rates is clearly stated in the caption of the renewal provision or in the brief description of the policy.

6. In a policy which provides for payment of benefits based on standards specified as "usual, customary and reasonable", such standards shall be defined in the policy and explained in the outline of coverage. Such standards shall not be more restrictive than:

i. "Usual" means the fee ordinarily charged by the provider for a particular service or supply.

ii. "Customary" means the range of usual fees charged by providers for the same service or supply under like circumstances within the geographic or socio-economic area where the service or supply is performed or furnished. The range of usual fees charged by the physicians shall consider training and experience.

iii. "Reasonable" means a fee above usual and customary which is justified by unusual complexity of the treatment required.

7. A policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or other words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

8. If a policy contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph in the policy and shall be labelled as "Pre-existing Condition Limitation".

9. If age is to be used as a determining factor for reducing the benefits available in the policy as originally issued, such fact must be prominently set forth in the policy and in the outline of coverage.

10. All policies, except short-term nonrenewable policies, Medicare supplement policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. With respect to Medicare supplement policies and policies issued pursuant to a direct response solicitation, the policy shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

11. An accident only policy shall contain a prominent statement on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for policy captions as follows: "This is an accident only policy. It does not pay benefits for loss from sickness."

12. If a policy contains a conversion privilege, the caption of the provision shall be "conversion privilege" or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

13. Where a policy provides a benefit that is payable while the insured is participating in a rehabilitation program the policy shall specify the type of rehabilitation program allowed and any limitations or restrictions on the program.

14. An informational brochure for persons eligible for Medicare by reason of age which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare, shall be furnished by each insurer to each such Medicare eligible person in connection with the purchase of a health insurance policy, other than a short-term nonrenewal policy, regardless of whether the policy purchased is advertised, solicited or issued as a Medicare supplement policy meeting the requirements of N.J.A.C. 11:4–23. The full text of the approved guide appears as an Appendix to subchapters 16 and 23 of this chapter, Exhibit A, and is entitled "Bridging the Medicare Gaps: A Guide to Medicare Supplements."

15. To ensure uniformity in the content, form and printing of the guide specified in (a)14 above, each insurer shall comply with the requirements of N.J.A.C. 11:4–23.11.

16. Delivery of the guide shall be made at the time of application except in the case of direct response solicitations where the guide shall be delivered with the policy. Acknowledgement of receipt of the guide shall be obtained by all insurers.

(b) Outline of coverage—general rules include:

1. No individual health insurance policy shall be delivered or issued for delivery in this State unless the appropriate outline of coverage in (c) through (n) below is completed as to such policy and:

i. For policies offered for sale as Medicare supplement policies, the outline meets the requirements set forth at N.J.A.C. 11:4–23.14; and

ii. For all other policies, the outline is either:

(1) Delivered with the policy; or

(2) Delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insurer.

2. If an outline of coverage was delivered at the time of application and the policy is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy must accompany the policy 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. Completed copies of all original and corrected outlines of coverage shall be retained by the insurer.

4. The appropriate outline of coverage for policies providing coverage which only meets the standards of N.J.A.C. 11:4–16.6(d) shall be that statement contained in N.J.A.C. 11:4–16.9(c). The appropriate outline of coverage for policies providing coverage which meets the standards of both N.J.A.C. 11:4–16.6(d) and (e) shall be the statement contained in N.J.A.C. 11:4–16.8(g). The appropriate outline of coverage for policies providing coverage which meets the standards of both N.J.A.C. 11:4–16.6(d), (e) or (f) shall be the statement contained in N.J.A.C. 11:4–16.8(f). The appropriate outline of coverage for policies providing coverage which meets the standards of N.J.A.C. 11:4–16.6(h), (i) or (k) when sold to Medicare eligible persons shall be the statement contained in N.J.A.C. 11:4–16.8(i), (k) or (n) respectively.

5. In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the

policy, an alternate outline of coverage shall be submitted to the Commissioner for prior approval.

6. The outline of coverage shall be printed in a style of general use. The size of type for statements contained in N.J.A.C. 11:4–16.8(c), (d), (e), (f), (g), (h), (j) and (m) shall not be less than 10 point, and for statements contained in N.J.A.C. 11:4–16.8(i), (k), (*l*) and (n) shall not be less than 12 point.

7. The outline of coverage shall specify a method for an applicant or insured to telephone a representative of the insurer other than the licensee to obtain information about policy benefits and claims. The method shall not require additional expense for the applicant or insured.

8. Parentheses in the outline of coverage indicate instructions or variable wording. Wording appropriate to the type of benefits should be used.

9. For the outline of coverage prescribed by N.J.A.C. 11:4–16.8(i), (k) and (n), the following instructions apply:

i. A dollar amount or percentage, as appropriate, shall be placed in each space of the "Insurance Pays" column. If the policy does not provide the coverage indicated, the space shall be completed with a zero and not left blank.

ii. The second sentence of item 2 of the outlines of coverage may be omitted from outlines required for direct policies in N.J.A.C. 11:4–16.8(b)9ii.

iii. The third sentence of item 2 of the outlines of coverage may be omitted from the outline required to be included in the solicitation or advertising material by N.J.A.C. 11:4–16.8(b)1ii.

(c) An outline of coverage regarding basic hospital expense coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4–16.6(d). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER—WHEN AVAILABLE)

BASIC HOSPITAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

1. Basic Hospital Expense Coverage. This type of policy is designed to cover you for hospital expenses incurred as a result of a covered accident or sickness. You are covered for: daily hospital room and board, miscellaneous hospital services, and hospital outpatient services. Benefits may be subject to any limitations and deductible set forth in the policy. Coverage is not provided for physicians' or surgeons' fees or unlimited hospital expenses.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have (10–30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____.

Benefit	Insurance Policy Pays
Hospital Room and Board	($_____ per day for _____ days) (_____% of semi-private charges for _____ days)
Miscellaneous Hospital Services	(up to $_____) (_____% of charges up to $_____)
Hospital Outpatient Services (List with any dollar limit)	$_____
Other Benefits (List)	_____

(You must pay a $_____ deductible each year before you can receive benefits.)

4. (A description of policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 3 above.)

5. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS, OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(d) An outline of coverage regarding basic medical-surgical expense coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4–16.6(e). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER—WHEN AVAILABLE)

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

1. Basic Medical-Surgical Expense Coverage—This type of policy is designed to cover you for medical and surgical expenses incurred as a result of a covered accident or sickness. You are covered for: surgical services, anesthesia services, and in-hospital medical services. Benefits are subject to any limitations and deductibles set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical and surgical expenses.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have (10–30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____.

Benefit	Insurance Policy Pays
Surgical Services	(____% of doctor's reasonable charges) (varies with service performed; up to $_____ for most expensive service)
Anesthesia Services	(____% of doctor's reasonable charges) (up to ____% of amount paid for surgery)
In-hospital Medical Services	(up to $_____ per day for _____ days) (____% of reasonable charges)
Other Benefits (List)	_____

4. For policies providing a second surgical opinion benefit the Notice(s) shown below shall be included when applicable.

NOTICE

This policy provides coverage for a second surgical opinion. However, your out-of-pocket expenses under this policy may be greater than your expenses under a similar policy which does not provide coverage for a second surgical opinion.

NOTICE

This policy requires to you obtain a second opinion before elective surgery is performed. If you fail to obtain the second opinion, benefits for surgery may be (denied or reduced).

5. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any manner operate to qualify payment of the benefits described in 3 above.)

6. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(e) An outline of coverage regarding policies combining basic hospital and medical-surgical expense in the form prescribed below shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4–16.6(d) and (e). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER—WHEN AVAILABLE)

BASIC HOSPITAL AND MEDICAL–SURGICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

1. Basic Hospital and Medical–Surgical Expense Coverage—This type of policy is designed to cover you for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. You are covered for: daily hospital room and board, miscellaneous hospital and hospital outpatient services, surgical and anesthesia services, and in-hospital medical services. Benefits may be subject to limitations and deductibles set forth in the policy. Unlimited hospital or medical and surgical expenses are not covered.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have (10–30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____.

Benefit	Insurance Policy Pays
Hospital Room and Board	($_____ per day for _____ days) (____% of semi-private charges for _____ days)
Miscellaneous Hospital Services	(up to $_____) (____% of charges up to $_____)
Hospital Outpatient Services (List with any dollar limits)	$_____
Surgical Services	(____% of doctor's reasonable charges) (varies with service performed, up to $_____ for most expensive service)
Anesthesia Services	(____% of doctor's reasonable charges) (up to ____% of amount paid for surgery)
In-hospital Medical Services	(up to $_____ per day for _____ days) (____% of reasonable charges)
Other Benefits (List)	_____

(You must pay a $_____ deductible each year before you can receive benefits.)

4. For policies providing a second surgical opinion benefit, the Notice(s) shown below shall be included when applicable:

NOTICE

This policy provides coverage for a second surgical opinion. However, your out-of-pocket expenses under this policy may be greater than your expenses under a similar policy which does not provide coverage for a second surgical opinion.

NOTICE

This policy requires you to obtain a second opinion before elective surgery is performed. If you fail to obtain the second opinion, benefits for surgery may be (denied or reduced).

5. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 3 above.)

6. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(f) An outline of coverage regarding major medical expense coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4-16.6(f). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER—WHEN AVAILABLE)

MAJOR MEDICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

1. Major Medical Expense Coverage—This type of policy is designed to cover you for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. You are covered for: daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care. Benefits may be subject to deductibles, copayment provisions, or other limitations set forth in the policy. (Basic hospital or basic medical expense coverage is not provided.)

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have 10–30 days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____.

Benefit	Insurance Policy Pays
Hospital Room and Board	($_____ per day for _____ days) (_____% semi-private charges for _____ days)
Miscellaneous Hospital Services	(up to $_____)
Out of Hospital Services	(_____% of covered charges)
Surgical Services	(_____% of doctor's reasonable charges) (varies with service performed, up to $_____ for most expensive service)
Anesthesia Services	(up to _____% of amount paid for surgery)
In-hospital Medical Services	(up to $_____ per day for _____ days) (_____% of reasonable charges)
Other Benefits (List)	_____

(Benefits are subject to a $_____ deductible each _____.)

(Benefits are subject to a deductible of the greater of $_____ or the amount of benefits provided by other medical insurance.)

Your copayment is (_____% of eligible charges.)

(This policy will pay up to $_____ during the lifetime of the policy.)

(This policy will pay up to $_____ for each _____.)

4. For policies providing a second surgical opinion benefit the Notice(s) shown below shall be included when applicable.

NOTICE

This policy provides coverage for a second surgical opinion. However, your out-of-pocket expenses under this policy may be greater than your expenses under a similar policy which does not provide coverage for a second surgical opinion.

NOTICE

This policy requires you to obtain a second opinion before elective surgery is performed. If you fail to obtain the second opinion, benefits for surgery may be (denied or reduced).)

5. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 3 above.)

6. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

7. (For policies providing coverage as defined in section 6(d)2, include the following statement: "This policy allows you to change the minimum deductible if your circumstances should ever change. You will be reminded of your right to change the deductible each year.")

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(g) An outline of coverage regarding disability income protection coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4–16.6(g). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER—WHEN AVAILABLE)

DISABILITY INCOME PROTECTION COVERAGE

OUTLINE OF COVERAGE

1. Disability Income Protection Coverage—This type of policy is designed to cover you for disabilities resulting from a covered accident or sickness. Benefits may be subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, medical and surgical, or major medical expenses.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have (10–30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____

(A brief specific description of the benefits contained in the policy.)

4. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 3 above.)

5. (A description of policy provisions respecting renewability or continuation of coverage, including, age restrictions or any reservation of right to change premiums.)

6. The following statement shall be included in policies which provide the benefit set forth in N.J.A.C. 11:4–16.6(g)2.

Information Statement

Each annual premium of $_____ for this policy includes a $_____ charge for the (Cash Value Provision). In the event of nonpayment of premium, death, or written request to surrender this policy before it has been in force for at least _____ years, the (cash value) payable will be less than the sum of the extra charges you have paid for the (Cash Value Provision). Therefore, you are cautioned that this policy should not be purchased unless you plan to continue it in force for _____ years or longer. You should also be aware that if the policy is maintained in force beyond _____ years, the time at which the potential (cash value) exceeds the charges for the (Cash Value Provision), the actual amount payable upon lapse, surrender, or death may be less than the charges for the (Cash Value Provision) if claim payments have been made under the policy.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(h) An outline of coverage regarding hospital confinement indemnity coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4–16.6(h). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER—WHEN AVAILABLE)

HOSPITAL CONFINEMENT INDEMNITY COVERAGE

OUTLINE OF COVERAGE

1. Hospital Confinement Indemnity Coverage—This type of policy is designed to pay you a fixed dollar amount each day that you are in the hospital as a result of a covered accident or sickness. (Certain other benefits are also provided.) Benefits may be subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical and surgical, or major medical expenses.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy you have (10–30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____

Benefit	Insurance Policy Pays
Indemnity While in Hospital (List other Benefits)	$_____ per day for up to _____ days beginning on the _____ day.

4. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 3 above.)

5. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(i) An outline of coverage regarding hospital confinement indemnity coverage sold to Medicare eligible persons, an outline of coverage, in the form prescribed below, shall be issued in connection with policies which meet the standards of N.J.A.C. 11:4–16.6(h) and which are sold to Medicare eligible persons. The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER—WHEN AVAILABLE)

HOSPITAL CONFINEMENT INDEMNITY COVERAGE FOR MEDICARE ELIGIBLE PERSONS

OUTLINE OF COVERAGE

1. Hospital Confinement Indemnity Coverage—This type of policy is designed to pay you a fixed dollar amount each day that you are in the hospital as a result of a covered accident or sickness. (Certain other benefits are also provided.) The policy is not designed to provide hospital and medical coverage for the costs not paid by Medicare.

2. Read Your Policy Carefully—This outline a coverage briefly describes the important features of your policy. (Your agent, broker or other company representative will explain each item to you so that you fully understand what you are buying.) For more information about the costs not paid by Medicare and what to look for in policy provisions, read the (Shopper's Guide) that was given to you with this form.

This form is not the insurance contract. Only the policy itself spells out the rights and obligations of both you and your insurance company. It is important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have (10–30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____

(After you have been in the hospital for _____ days), this policy will pay you $_____ per day (up to _____ days).

(List other benefits).

4. This policy does not pay you benefits for:

_____ hospital charges
_____ skilled nursing facility charges
(_____ doctors' charges)

5. (A description of any policy provisions which will exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 3 above.)

6. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(j) An outline of coverage regarding accident only coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4–16.6(i). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER—WHEN AVAILABLE)

ACCIDENT ONLY COVERAGE

THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

OUTLINE OF COVERAGE

1. Accident Only Coverage—This type of policy does not pay you benefits if you get sick. It covers you for certain losses resulting from a covered accident ONLY. Limitations on benefits may apply. Basic hospital, basic medical and surgical, or major medical coverage is not provided.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy you have (10–30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____

(A brief specific description of the benefits contained in this policy. Note: This description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with section 5(b) of this subchapter.)

4. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of benefits described in 3 above. If benefits vary according to the type of accidental cause, describe prominently the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.)

5. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(k) An outline of coverage regarding accident only coverage for Medicare eligible persons, in the form prescribed below, shall be issued in connection with policies which meet the standards of N.J.A.C. 11:4–16.6(i) and which are sold to Medicare eligible persons. The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER—WHEN AVAILABLE)

ACCIDENT ONLY COVERAGE

FOR MEDICARE ELIGIBLE PERSONS

OUTLINE OF COVERAGE

1. Accident Only Coverage—This type of policy does not pay you benefits if you get sick. It covers you for certain losses due to a covered accident ONLY. Limitations on benefits may apply. The policy does not provide hospital and medical coverage for the costs not paid by Medicare.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. (Your agent, broker or other company representative will explain each item to you so that you fully understand what you are buying.) For more information costs [1] not paid by Medicare and what to look for in policy provisions, read the (Shopper's Guide) that was given to you with this form.)

This form is not the insurance contract. Only the policy itself spells out the rights and obligations of both you and your insurance company. It is important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have (10–30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____

(A brief specific description of the benefits contained in this policy. Note: The above description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Section 5(b) of this subchapter.)

4. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of benefits described in 3 above. If benefits vary according to the type of accidental cause, describe prominently the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.)

5. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(*l*) An outline of coverage regarding Medicare supplement coverage, shall be issued in connection with policies in compliance with N.J.A.C. 11:4–16.6(j). The outline of coverage shall meet the requirements of N.J.A.C. 11:4–23.14.

(m) An outline of coverage regarding limited benefit health coverage in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of N.J.A.C. 11:4–16.4(d), (e), (f), (g), (h), and (j). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER—WHEN AVAILABLE)

LIMITED BENEFIT HEALTH COVERAGE

OUTLINE OF COVERAGE

1. Limited Benefit Health Coverage—This type of policy will provide you with limited or supplemental benefits only. It is not designed to provide you with basic hospital, basic medical and surgical or major medical coverage.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you

have (10–30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____

(A brief specific description of the benefits, including dollar amounts, contained in this policy. Note: The above description of benefits shall be stated clearly and concisely and shall include a description of any deductible or copayment provisions applicable to the benefits described.)

4. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 3 above.)

5. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(n) An outline of coverage regarding limited benefit health coverage sold to Medicare eligible persons, in the form prescribed below, shall be issued to Medicare eligible persons in connection with policies which do not meet the minimum standards of N.J.A.C. 11:4–16.6(d), (e), (f), (g), (h), (i) and (j). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)

(POLICY NUMBER WHEN AVAILABLE)

LIMITED BENEFITS HEALTH COVERAGE

FOR MEDICARE ELIGIBLE PERSONS

OUTLINE OF COVERAGE

1. Limited Benefit Health Coverage—This type of policy will provide you with limited benefits only. It is not designed to provide hospital and medical coverage for the costs not paid by Medicare.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. (Your agent, broker and other company representatives will explain each item to you so that you fully understand what you are buying.) For more information about the costs not paid by Medicare and what to look for in policy provisions, read the (Shopper's Guide) that was given to you with this form.

This form is not the insurance contract. Only the policy itself spells out rights and obligations of both you and your insurance company. It is important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have (10–30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____

Inpatient Hospital Benefits	**Medicare—Part A**	**Insurance Policy Pays**
You are hospitalized during a benefit period for:		
Up to 60 days	**You pay the first $_____ deductible. Medicare pays balance.**	**$_____**
61 to 90 days	**You pay $_____ copayment. Medicare pays balance.**	**$_____**
91 to 150 days	**You pay $_____ copayment. Medicare pays balance.**	**$_____**
Beyond 150 days	**You pay all cost. Medicare pays nothing.**	**$_____**
Skilled Nursing Facility Benefits	**Medicare—Part A**	**Insurance Policy Pays**
You are admitted to a skilled nursing facility. You are a patient in this facility for up to 20 days during a benefit period.	**You pay nothing. Medicare pays 100%.**	**$_____**
You remain in the facility for any of the next 80 days— 21st-100th day.	**You pay $_____ copayment per day. Medicare pays balance of reasonable costs.**	**$_____ per day**

You remain in the facility after 100 days of comfinement.	You pay full amount. Medicare pays nothing.	$_____ per day.*

*Payment will only be made if the skilled nursing facility is approved by Medicare and if the care given is medically necessary. NEITHER MEDICARE NOR THIS POLICY WILL PAY FOR CUSTODIAL CARE OR REST HOME CARE.

Medical Service Benefits	Medicare—Part B	Insurance Policy Pays
You receive physician services, medical supplies, ambulance and other covered services.	You pay the first $_____ deductible. Medicare pays 80% of the remaining "reasonable and necessary" charge.	$_____
	You pay the remaining 20% of the "reasonable and necessary" charge while you are in the hospital.	Medicare eligible expenses to the extent not covered by Medicare after you have paid $_____ of these charges.
	You pay the remaining 20% of the "reasonable and necessary" charge when you are not hospitalized.	Medicare eligible expenses to the extent not covered by Medicare after you have paid $_____ of these charges.
	You pay the portion of the bill that exceeds the "reasonable and necessary" charge.	_____**

**Unless this space is filled in with a specific dollar amount or percentage, the policy will not pay for charges that exceed Medicare's determination of "reasonable and necessary" charges.

4. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in 3 above.)

5. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL-FREE) (LOCAL NUMBER) _____.

(*o*) The warning captions listed below shall be displayed prominently in large type on a separate half-sheet which shall be attached to the first page of the outline of coverage.

1. For policies sold to Medicare eligible persons which do not meet the minimum standards for coverage set forth in N.J.A.C. 11:4–16.6(j) but which do provide coverage for confinement or care in a skilled nursing facility:

"ATTENTION POLICYHOLDER: THE PROVISIONS OF THIS POLICY DO NOT RELATE IN ANY WAY TO MEDICARE. THIS POLICY DOES NOT COVER CUSTODIAL CARE (HELP IN MEETING YOUR PERSONAL NEEDS) OR REST HOME CARE."

2. For accident only policies sold to Medicare eligible persons:

"ATTENTION POLICYHOLDER: THIS IS AN ACCIDENT ONLY POLICY. IT DOES NOT PAY YOU BENEFITS IF YOU GET SICK. THIS POLICY DOES NOT PROVIDE HOSPITAL AND MEDICAL COVERAGE FOR THE COSTS NOT PAID BY MEDICARE."

3. For limited benefit health insurance policies sold to Medicare eligible persons:

"ATTENTION POLICYHOLDER: THIS POLICY PROVIDES LIMITED BENEFITS ONLY. IT DOES NOT PROVIDE HOSPITAL AND MEDICAL COVERAGE FOR THE COSTS NOT PAID BY MEDICARE."

Amended by R.1985 d.68, effective February 19, 1985 (operative June 19, 1985).
See: 16 N.J.R. 2944(a), 17 N.J.R. 459(a).
(1)4 added. Old 4.–5. renumbered to 5.–6.
Amended by R.1987 d.96, effective February 2, 1987.
See: 18 N.J.R. 2103(a), 19 N.J.R. 291(a).
Amended (a)14; added (a)15 and 16.
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)14 and (a)15iii: revised internal citations and references; deleted (a)15iv, which was outdated text. In (a)15ii(3) and (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).
Added reference to "Medicare supplement policies" in (a)10.
Added ", regardless of whether the policy purchased is advertised, solicited or issued as a Medicare supplement policy meeting the requirements of N.J.A.C. 11:4–23." in (a)14.
Added "specified in (a)14 above" and "of N.J.A.C. 11:4–23.11" in (a)15.
Deleted (a)15i, ii, iii.
Deleted "section 8" and "of this subchapter"; added "below" in (b)1.
Deleted "Supplement Coverage" and "is delivered to the applicant at the time application is made and, except for the direct response policy, acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the insured"; added "supplement policies" and "meets the requirements set forth at N.J.A.C. 11:4–23.11" in (*l*).
Deleted "Medicare Supplement Coverage–Outline of Coverage" chart in (*l*).

Added to "Outline of Coverage" chart in (n) as follows: deleted "for an unlimited number of days per calendar year" and added benefit periods for "up to 60 days", "61 to 90 days", "91 to 150 days" and "Beyond 150 days" under "Inpatient Hospital Benefits" with corresponding space for copayment under "Medicare Part A" and "Insurance Policy Pays". Changed "8" days to "20" days; changed "142 days–9th–150th days" to "80 days–21st–100th day" and "150" days to "100" days of confinement in the "Skilled Nursing Facility Benefits" column. Changed "you pay $_____ per day. Medicare pays balance of reasonable cost." to "you pay nothing. Medicare pays 100%*."; changed "You pay nothing. Medicare pays 100%.*" to "you pay $_____ copayment per day. Medicare pays balance of reasonable costs." in "Medicare—Part A."
Amended by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).
Citations revised.

[1] So in original.

11:4–16.9 Forms submission requirements

(a) General rules include:

1. Within 120 days after the effective date of this regulation, each issuer shall submit a list of all individual health insurance forms currently filed which meet the requirements contained herein. An executive officer of the company shall certify that the forms listed comply with this regulation.

2. Each form submitted for filing by the commissioner shall be accompanied by an individual health insurance report as specified in section 9(c) of this subchapter.

3. Each submission shall include a description of the marketing arrangements for the form(s). This description should specify the intended use and purpose of the form, the methods by which the form will be sold, and the segment of the general public that is expected to make up the largest portion of applicants. If the form will be solicited by mail or any mass marketing scheme, the submission shall also include copies of advertising materials.

4. The application form and any riders, endorsements or amendments which are required to be attached at issue shall be included with the submission.

5. Each form shall be filled in with hypothetical data as for specimen issue.

6. Each rider, amendment or endorsement shall specify the forms with which it will be used and shall indicate any changes in benefits, coverages, exclusions or rates that will result.

7. A rubber stamp endorsement shall be shown on a specimen policy page as it will appear in actual use.

8. Wording in any form which is to be considered variable shall be appropriately indicated, and any alternate wording shall be included with the submission.

(b) Rules concerning additional material required for submission include:

1. This department does not sanction wholesale terminations of individual policies in this State. Therefore, whenever a form is submitted which reserves to the insurer the right to nonrenew the policy for a reason stated in N.J.A.C. 11:4–16.4(a)17, the insurer shall include with the submission a letter from an officer of the company agreeing to the following conditions:

i. That the insurer has designed the policy, rates, underwriting and issue procedures so that it will not be necessary to exercise such right of nonrenewal;

ii. That in the remote chance the insurer does find it necessary to exercise such right, it shall give this department full information as to the reasons for nonrenewal and at least 90 days notice prior to taking any nonrenewal action;

iii. That the insurer will discuss with this department all possible alternatives, including the remedy of offering appropriate substitute coverage which gives full credit for all prior waiting periods; and

iv. That such action will only be taken as a last resort.

2. The insurer shall include with the submission of forms that include an option to purchase additional insurance an agreement to send the notice required by N.J.A.C. 11:4–16.6(c)20iv.

3. The insurer shall include with the submission of forms that meet the requirements of N.J.A.C. 11:16–4.6(f)2 an agreement to send the notice required by N.J.A.C. 11:4–16.6(f)2iv.

4. The insurer shall include with the submission of forms which provide benefits that fluctuate with the cost of living (consumer price index) any advertising or promotional material including instructions to its agents. Such material shall make it clear that the benefit is not necessarily protection against increases in the cost of living.

5. In submitting forms where the premium may be paid through credit card facilities, the insurer shall agree that the premium will be considered paid when the credit card facility is billed.

6. Where policies are to be sold through vending machines, the insurer shall agree to the following:

i. That a record will remain in the vending machine; and

ii. That the insurer will canvass the machines after each and every accident and notify all applicable beneficiaries.

(c) Individual health insurance report rules are:

1. A copy of the individual health insurance report required by section 9(a)2 of this subchapter will be furnished to each insurer by this department.

11:4–16.10 Separability

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

11:4–16.11 Penalties

If after notice and hearing the commissioner finds that a person has violated this regulation, a penalty, in addition to any other penalty, not exceeding $2,000 for each violation may be imposed and shall be collected and enforced pursuant to the law (N.J.S. 2A:58–1 et seq.).

APPENDIX A

N.J.A.C. 11:4–16.9(a)2 requires that an Individual Health Insurance Report be submitted with each policy form. The form below shall be used for this report.

Individual Health Insurance Report
Policy Form Information

Insurer .....

Submittal Date	Submitting: Policy [ ] Rider [ ] Rates [ ]
Form No.	Title (descriptive name) .....
Replaced Form No.	Other Forms with similar coverage .....
Issue Ages ..... to	Form issued from ..... 19... to ..... 19...

Type of Business: Ordinary [ ] MDO [ ] Industrial [ ] Group Conversion [ ]
Rider will be attached to Form .....

Renewal Provision:

Noncancellable	[ ]	Guaranteed Renewable	[ ]
Nonrenewable for stated reasons	[ ]	Short term nonrenewable	[ ]
Collectively Renewable	[ ]	Other	[ ]

Coverage:

Basic Hospital Expense	[ ]	Hospital Confinement Indemnity	[ ]
Basic Medical–Surgical Expense	[ ]	Accident Only	[ ]
Major Medical	[ ]	Medicare Supplement	[ ]
Disability Income	[ ]	Other (Specify other benefits)	[ ]

Benefit Limits:

	From	To	Most Common
Deductible	$.....	$.....	$.....
Hospital Room and Board	$.....	$.....	$.....
Surgical Schedule	$.....	$.....	$.....
Hospital Miscellaneous Expense	$.....	$.....	$.....
Income Per	$.....	$.....	$.....
Elimination Period	.....	.....	.....
Benefit Period	.....	.....	.....
Other (list)	.....	.....	.....

Other states where filed (Approved) .....

SUBCHAPTER 17. HEALTH INSURANCE SOLICITATION

Subchapter Historical Note

All provisions of this subchapter were filed and became effective on April 21, 1980, as R.1980 d.176. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c). On June 12, 1980 the Legislature adopted Senate Concurrent Resolution 110 disapproving this subchapter pursuant to N.J.S.A. 17B:26–45d. On August 5, 1980 the Department of Insurance readopted the subchapter in its entirety, with amendments to N.J.A.C. 114–17.6 and 17.7, as R.1980 d.343. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b). This subchapter was readopted pursuant to Executive Order 66(1978), effective April 15, 1985 as R.1985 d.221. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a). See chapter and section levels for further amendments.

11:4–17.1 Purpose

The purpose of this rule is to eliminate unfair and deceptive practices in the promotion, solicitation, and sale of individual health insurance.

11:4–17.2 Applicability and scope

This regulation shall apply to all individual health insurance policies delivered or issued for delivery in this state on or after the effective date hereof except that it shall not apply to conversion policies issued pursuant to a contractual conversion privilege or to credit health insurance. This regulation shall be in addition to any other applicable regulations previously adopted.

11:4–17.3 Definitions

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

"Duplicative coverage" means a transaction wherein health insurance is to be purchased and it is known or should be known to the licensee or the insurer in the case of a direct response solicitation, that the insurance will provide coverage which, when combined with existing coverage, is likely to result in total claim payments, in the event of loss, in amounts greater than the actual amount of loss.

"Licensee" means any person licensed as an insurance agent, broker or consultant pursuant to N.J.S.A. 17:22A–1 et seq.

"Policy" means the entire contract between the insurer and the insured, including, but not limited to, the policy, certificate, riders, endorsements, amendments and the application which are required to be filed pursuant to N.J.S.A. 17B:26–1 and N.J.S.A. 17:44A–21.

"Replacement" means a transaction wherein individual health insurance is to be purchased and it is known or should be known to the licensee or the insurer in the case of a direct response solicitation that due to the transaction previously existing health insurance has been, or will be, lapsed, cancelled or otherwise terminated.

"Sales materials" means any and all promotional materials and any other informational material used in connection with the promotion, solicitation, or sale of health insurance.

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).
In "Licensee": changed "solicitor" to "consultant," and revised N.J.S.A. citation.

11:4–17.4 Unfair and deceptive acts

(a) No person shall engage in any unfair, deceptive, misleading, or unreasonably confusing practice in the promotion, solicitation or sale of individual health insurance.

(b) The following acts and practices shall be deemed prima facie evidence of a violation of this regulation and of demonstrated unworthiness on the part of any licensee or insurer:

1. Any act tending to induce an applicant or other person to purchase duplicative coverage;

2. Encouraging an applicant to omit pertinent underwriting information from an application for health insurance;

3. Any act tending to induce a prospective insured to sign a blank or incomplete application or form;

4. Failure to disclose upon initial contact with a prospective applicant the licensee's affiliation with an insurance company.

5. Any representations, expressed or implied, unless the licensee has been specifically authorized in writing by the organization, that the licensee is affiliated with or authorized by any civic, social, government or other organization;

6. Making any false or misleading statements as to the length of time an insurance offering may or may not be available;

7. The sale of any policy withdrawn from or disapproved for filing as not in compliance with the New Jersey insurance laws or regulations;

8. Selling Medicare supplement insurance to any person not eligible for Medicare;

9. Falsely answering any question or signing any certification in an application or in any other form required to be completed by the licensee; or

10. Failure to remit, within seven business days, the amount of premium collected from an applicant that is due the company.

11:4–17.5 Replacement

(a) All licensees involved in the sale of individual health insurance shall diligently inquire of each applicant as to the existence of any health insurance on any proposed insured. The licensee shall obtain either in the application or in a separate form, a statement, dated and signed by the applicant, indicating whether any health insurance is presently in force, the names of the companies which issued the insurance, the type of coverage, and where possible the policy number.

(b) For direct response solicitations, application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any health insurance presently in force.

(c) Upon determining that a sale will involve replacement, a licensee shall at the time of the application, furnish the applicant with the notice described in section 5(d) of this subchapter. One copy of such notice shall be delivered to the applicant and an additional copy signed by the applicant shall be submitted with the application and retained by the insurer. A direct response insurer shall, upon issuance of the policy, deliver to the applicant the notice described in section 5(e) of this subchapter. In no event, however, will such a notice be required in the solicitation of accident only and single premium short-term nonrenewable policies.

(d) The notice required by section 5(c) of this subchapter for a licensee shall be as follows:

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing health insurance and replace it with a policy issued by (insert Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

(e) The notice required by section 5(c) of this subchapter for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing health insurance and replace it with the policy delivered herewith issued by (insert Company Name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Company Name)

(f) Item 1 of the notices required by section 5(d) and (e) of this subchapter may be omitted if the replacement policy covers all pre-existing conditions from the effective date of coverage.

11:4–17.6 Complaint record to be maintained

(a) N.J.S.A. 17B:30–13.2 requires the maintenance of complaint records. The following requirements prescribed the minimum information to be maintained in order to comply with the statute.

1. The minimum information required to be contained in a person's complaint record is set forth in (b) below. Refinements and additions to the information specified may, of course, be maintained in such complaint record.

2. Subsection (b) of this section is the suggested format for the complaint record required to be maintained. Refinements, deviations from or additions to this suggested format are permitted so long as the minimum information contemplated by such format can be obtained for Insurance Department review within a reasonable time following a request therefor by an authorized representative of the Department.

3. Subsection (c) of this section contains an explanation of the various headings, codes, and other notations contained in section (b) of this section. The codes are used in order to simplify both the identification of the action underlying the complaint and the keeping of the records.

4. The complaint record shall be kept on a calendar year basis and the number of complaints by line of insurance, function, reason, disposition and state of origin shall be compiled at least annually.

5. "Complaint" shall mean a written communication primarily expressing a grievance.

(b) Complaint record format:

COMPLAINT RECORD FORMAT

Column A	Column B		Column C	Column D	Column E	Column F	Column G	Column H
Company Identification No. (Agent's Number)	Function Code	Reason Code	Line Type	Company Disposition after Complaint receipt	Date Received	Date Closed	Insurance Dept. Complaint	State of Origin

(c) Explanation of complaint record code for Complaint Record Format in (b) above follows:

Column A: Company Identification Number. As noted, this refers to the identification number of the complaint and shall also include the license number or other means of identifying any licensee of the Insurance Department that may have been involved in the complaint.

Column B: Function Code. Complaints are to be classified by function(s) of the company involved. Separate classifications are to be maintained for underwriting,

marketing and sales, claims, policy holder service and miscellaneous.

Column B: Reason Code: Complaints are also to be classified by the nature of the complaint. The following is the classification required for each function specified above.

1. Underwriting:
   a) Company underwriting;
   b) Individual's application underwriting (this refers to any complaint where misrepresentations or declarations in an application for insurance resulted in company action involved in the complaint);
   c) Cancellation;
   d) Recision;
   e) Nonrenewal;
   f) Premiums and rating;
   g) Delays;
   h) Refusal to insure;
   i) Miscellaneous (not covered by above).
2. Marketing and sales:
   a) General advertising;
   b) Direct response advertising;
   c) Agent handling;
   d) Replacement;
   e) Dividend illustration;
   f) Delays;
   g) Alleged misleading statement or misrepresentation;
   h) Miscellaneous (not covered by above).
3. Claims:
   a) Claims procedure;
   b) Delays;
   c) Unsatisfactory settlements;
   d) Natural disaster adjusting (hurricane or flood situations or other situations which produce a large number of claims);
   e) Unsatisfactory settlement offers;
   f) Denial of claim;
   g) Miscellaneous (not covered by above).
4. Policyholder service:
   a) Failure to respond;
   b) Delays;
   c) Miscellaneous (not covered by above).
5. Miscellaneous:

Column C: Line Type. Complaints are to be classified according to the line of insurance involved. To complete this column, insert (9) which indicates individual health.

Column D: Company Disposition After Receipt. The complaint record shall note the disposition of the complaint.

The following examples illustrate the type of information called for, but are not intended to be required language or to exhaust the possibilities:

1. Corrective action was taken;
2. No action was deemed necessary;
3. Satisfactory explanation was given to the complainant.

The complainant record need not note the specific action taken with respect to the complaint, so long as the action was appropriate to the circumstances. If the company wishes it may use a code for entries in this column.

Column E: Date Received. This refers to the date the complaint was received.

Column F: Date Closed. This refers to the date on which the complaint was disposed of whether by one action or a series of actions as may be present in connection with some complaints.

Column G: Insurance Department Complaint. Complaints are to be classified so as to indicate if the origin of the complaint was from an Insurance Department.

Column H: State of Origin. The complaint record should note the state from which the complaint originated. Ordinarily this will be the state of residence of the complainant.

11:4–17.7 Penalties

(a) Any person who, after notice and hearing, is determined by the Commissioner to be in violation of this regulation shall be liable to a penalty not exceeding $2,000 for each violation. In addition to, or in lieu thereof, the Commissioner may revoke or suspend the license or certificate of authority of any such agent, broker, consultant, or insurer.

(b) An insurer may be held legally accountable for violations of this regulation by any of its agents. If any agent is fined pursuant to this regulation, an equivalent fine may be levied against the insurer responsible for the agent's actions.

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).
In (a): changed "solicitor" to "consultant."

11:4–17.8 Separability

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

11:4–17.9 Effective date

This regulation shall be effective after it has been accepted by the Legislature. Acceptance by the Legislature will occur 60 days after the regulation has been submitted to the Legislature, unless the Legislature passes a concurrent resolution stating in substance that the Legislature does not favor this regulation.

SUBCHAPTER 18. INDIVIDUAL HEALTH INSURANCE RATE FILINGS

Subchapter Historical Note

All provisions of this subchapter were filed and became effective on April 21, 1980, as R.1980 d.176. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c). On June 12, 1980 the Legislature adopted Senate Concurrent Resolution 110 disapproving this subchapter pursuant to N.J.S.A. 17B:26–45d. On August 5, 1980 the Department of Insurance readopted the subchapter in its entirety as R.1980 d.343. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b). This subchapter was readopted pursuant to Executive Order 66(1978), effective April 15, 1985 as R.1985 d.221. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a).

11:4–18.1 Purpose

The purpose of this subchapter is to record the policies and practices which the commissioner has traditionally applied to assure that individual health insurance benefits are reasonable in relation to the premiums charged, as required by N.J.S.A. 17B:26–1h, and to further expand those policies and practices in order to comply with the additional requirements of Chapter 78 of the Laws of 1979.

11:4–18.2 Applicability and scope

This regulation shall apply to all individual health insurance policies delivered or issued for delivery in this state, except that it shall not apply to conversion policies issued pursuant to a contractual conversion privilege and it shall not apply to credit health insurance as defined by N.J.S.A. 17B:29–2b. Nothing in this regulation may be construed so as to limit or waive the responsibilities otherwise imposed on insurers, with respect to the form and content of individual health insurance policies, by Chapter 26 of Title 17B—the Life and Health Insurance Code.

11:4–18.3 Definitions

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

1. Terms related to policy renewability are:

i. "Collectively renewable insurance" means all insurance which is made available on any individual basis under mass enrollment procedures to persons under a plan sponsored by an employer, association, or union, or to a group of individuals supplying materials to a central point of collection or handling a common product or commodity, under which the insurer has agreed that renewal will not be refused, subject to any specific age limit, while the insured remains a member of the group specified in the agreement, unless the insurer simultaneously refuses to renew all policies in the same group or all policies bearing the same form number.

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

iii. "Nonrenewable for stated reasons only insurance" means all individual insurance which limits the insurer's right of nonrenewal to stated reasons.

iv. "Noncancellable insurance" or "noncancellable and guaranteed renewable insurance" means all individual insurance which gives the insured the right to continue the insurance in force by the timely payment of premiums set forth in the policy until at least age 50, or in the case of a policy issued after age 44 for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while it is in force.

2. Terms related to loss ratios are:

i. "Incurred/earned loss ratio" means the ratio of incurred claims to earned premiums.

ii. "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.

iii. "Aggregate loss ratio" means the ratio of items (1) to (2) below, where:

(1) Is the accumulated value of past benefits, from the original effective date of a form to the date as of which the ratio is determined, and the present value of future benefits; and

(2) Is the accumulated value of past premiums from the original effective date of that form to the date as of which the ratio is determined, and the present value of future premiums.

NOTE: For purposes of the "aggregate loss ratio", benefits shall not be increased nor premiums reduced by actual or anticipated dividends, and interest shall be included in the accumulated values and present

values on the same basis as in the present values for the "anticipated loss ratio".

3. Other terms are:

i. "Accident only coverage" means all individual insurance which covers only losses due to accident.

ii. "Over 65 coverage" means all individual insurance where premiums are rated by age and the attained age is 65 years or more or when the insurance is issued only to persons age 65 or more.

iii. "Policy" means any policy, certificate, rider, endorsement or amendment which is required to be filed pursuant to N.J.S.A. 17B:26–1 and N.J.S.A. 17:44A–21.

Amended by R.1988 d.473, effective October 3, 1988 (operative January 31, 1989).
See: 19 N.J.R. 1620(b), 20 N.J.R. 2457(c).
Substantially amended.

11:4–18.4 Rate submission requirements

(a) Each insurer shall include with each submission of new or revised rates the following information and material:

1. An actuarial memorandum which shall include the following:

i. The anticipated loss ratio;

ii. The specific formulas and methodology used in calculating gross premiums;

iii. An explanation and documentation supporting the premium assumptions;

iv. The objective basis for rate differentials; and

v. A certification signed by the company's Actuary that the information given in the actuarial memorandum is appropriate and that the benefits provided are reasonable in relation to the premiums charged.

2. In connection with rate revisions only, the aggregate loss ratio, a statement of the reason for the revision, and an estimate of the expected average increase or decrease in premium both in dollars and percent.

11:4–18.5 Loss ratio standards

(a) For new forms, the benefits provided are presumed reasonable in relation to the premiums charged if the anticipated loss ratio meets the following standards:

1. For over 65 coverage, the ratio is at least 65 percent;

2. For accident only coverage, the ratio is at least 50 percent;

3. For short term nonrenewable trip policies which do not cover loss due to sickness, the ratio is at least 40 percent;

4. For coverage other than as listed in 1, 2 and 3 above and which are:

i. Collectively renewable insurance, the ratio is at least 60 percent;

ii. Guaranteed renewable insurance or nonrenewable for stated reasons only insurance, the ratio is at least 55 percent;

iii. Noncancellable insurance or noncancellable and guaranteed renewable insurance, the ratio is at least 50 percent.

5. For any insurance not listed in (a)1 through (a)4 above, the ratio is at least 55 percent.

(b) With respect to filings of rate revisions for previously approved policy forms, benefits shall be deemed reasonable in relation to premiums if both the anticipated loss ratio and the aggregate loss ratio satisfy these loss ratio standards.

Amended by R.1988 d.473, effective October 3, 1988.
See: 19 N.J.R. 1620(b), 20 N.J.R. 2457(c).
Deleted text in (a)4 "policies which provide".

11:4–18.6 Annual review of calendar year experience data on filed individual health insurance policy forms

(a) Each insurer shall maintain records of premiums, claims, and reserves on each policy form as required for the accident and health policy experience exhibit.

(b) If the incurred/earned loss ratios for a particular policy form, based on a substantial volume of reasonably mature business, do not meet the standards set forth in section 5 of this subchapter, the insurer will be required to explain why the premiums should not be regarded as unreasonably high in relation to the benefits provided. After consideration of the explanation and any additional information furnished by the insurer, the department will inform the insurer if the benefits provided are considered unreasonable in relation to the premiums charged. If within 90 days thereafter the insurer does not reduce the premiums or increase the benefits provided in the policy such that the standards set forth in section 5 of this subchapter are met, the department may commence proceedings as provided by law for withdrawal of the filing of the form.

Amended by R.1995 d.327, effective June 19, 1995.
See: 27 N.J.R. 1513(a), 27 N.J.R. 2407(a).
Deleted (b) and relettered former (c) as (b).

11:4–18.7 Rate manual

(a) Each insurer shall maintain on file with the department an up-to-date rate manual for all individual health insurance policies, riders, and endorsements currently available for sale in New Jersey. Such manual shall include:

1. Name of the insurer on each page;

2. Table of contents or index; and

3. Identification by form number of each policy, rider, and endorsement to which the rates apply.

11:4–18.8 Separability

If any provisions of this regulation or the application thereof to any person or circumstance shall be held invalid, the invalidity shall not affect the provisions or application of this regulation which can be given effect without the invalid provision or application, and for this purpose, the provisions of this regulation are separable.

11:4–18.9 Penalties

If, after notice and hearing the commissioner finds that a person has violated this regulation a penalty, in addition to any other penalty, not exceeding $2,000 for each violation may be imposed and shall be collected and enforced pursuant to the law (N.J.S.A. 2A:58–1 et seq.).

11:4–18.10 Compliance

All policies of insurance previously filed with the Commissioner which are not in compliance with this subchapter as of the operative date shall be deemed to be withdrawn from filing and disapproved. No new policy of insurance shall be delivered or issued for delivery in this State until the policy has been filed with the Commissioner.

Amended by R.1988 d.473, effective October 3, 1988 (operative January 3, 1989).
See: 19 N.J.R. 1620(b), 20 N.J.R. 2457(c).
Deleted old text and substituted new.

SUBCHAPTER 19. OPTIONAL COVERAGE FOR PREGNANCY AND CHILDBIRTH BENEFITS

Subchapter Historical Note

Subchapter 19 was adopted as R.1988 d.455, effective September 19, 1988. See: 20 N.J.R. 43(a), 20 N.J.R. 2377(c).

11:4–19.1 Purpose

The purpose of this subchapter is to prevent the exclusion of pregnancy-related surgery and sterilization procedures from certain second surgical opinion programs and to make maternity coverage available to insureds.

11:4–19.2 Scope

This subchapter shall apply to all group and individual health insurance policies as well as hospital and medical service corporation contracts delivered or issued for delivery in this State. This subchapter shall not apply to health service corporation contracts.

11:4–19.3 Second surgical opinions

Every health insurer and medical service corporation offering individual and group policies in this State, with the exception of hospital service corporations, shall include in its programs for second surgical opinions, coverage for pregnancy-related surgery and sterilization procedures.

11:4–19.4 Maternity benefits option

(a) Each insurer shall make available benefits coverage for maternity care without regard to the marital status of its policyholders, subscribers or other persons thereunder covered for expenses incurred in pregnancy and childbirth.

(b) The amount of or type of benefit coverage for maternity care expenses incurred in pregnancy and childbirth shall be provided to the same extent as benefits coverage is provided in policies and contracts for any other covered illness. Where a fixed amount of benefit coverage for surgery is prescribed by a policy or contract, benefit coverage for pregnancy-related surgical procedures shall be commensurate to that for surgery of comparable difficulty and severity.

(c) Policies which provide normal pregnancy and childbirth benefits shall cover pregnancy if conception occurs after the effective date of coverage or after a probationary period of not more than 30 days after the effective date of the coverage.

(d) Each insurer is required to give a single notice of the option to select maternity benefits coverage to its policyholders or subscribers. While no notice of the availability of such coverage is required to be made at every renewal of a policy, the coverage itself must be made available at renewal, for the option of selection by the insured.

SUBCHAPTER 20. BLINDNESS; PARTIAL BLINDNESS OR OTHER PHYSICAL OR MENTAL IMPAIRMENTS; UNFAIR DISCRIMINATION

Subchapter Historical Note

All provisions of this subchapter were filed and became effective December 6, 1979 as R.1979 d.434. See: 11 N.J.R. 384(a), 11 N.J.R. 627(f). A readoption became effective April 1, 1990 pursuant to Executive Order 66(1978) as R.1985 d.161. See: 17 N.J.R. 168(a), 17 N.J.R. 820(a). See chapter and section levels for further amendments.

11:4–20.1 Purpose

The purpose of this subchapter is to eliminate unfair discrimination in the underwriting, insuring and rating of individuals who are normal insurance risks in spite of blindness, partial blindness, or other physical or mental impairments.

11:4–20.2 Unfair discriminatory acts or practices

(a) The following are hereby identified as acts or practices which constitute unfair discrimination between individuals of the same class:

1. Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a

different rate for the same coverage solely because of blindness, partial blindness or other physical or mental impairments, except where the refusal, limitation or rate differential is based on sound, actuarial principles or is related to actual or reasonably anticipated experience.

Case Notes

Statute proscribing discrimination in terms and conditions of employee's health insurance policy regulated insurance within meaning of ERISA's savings clause. PAS v. Travelers Ins. Co., C.A.3 (N.J.)1993, 7 F.3d 349.

SUBCHAPTER 21. LIMITED DEATH BENEFITS FORMS

Subchapter Historical Note

All provisions of this subchapter became effective June 18, 1980 as R.1980 d.265. See: 12 N.J.R. 279(b), 12 N.J.R. 423(c). This subchapter was readopted pursuant to Executive Order 66(1978) effective June 3, 1985 as R.1985 d.325. See: 17 N.J.R. 891(a), 17 N.J.R. 1660(a). Sections 1, 2 and 4 were amended and sections 3 and 5 were adopted as New Rules effective July 1, 1985 (operative September 1, 1985) as R.1985 d.325. See: 17 N.J.R. 891(a), 17 N.J.R. 1660(a).

The subchapter was completely amended effective July 20, 1987 (operative September 18, 1987) as R.1987 d.306. See: 19 N.J.R. 843(b), 19 N.J.R. 1320(a). See chapter and section levels for further amendments.

11:4–21.1 Purpose; scope

(a) The purpose of this subchapter is to establish guidelines for the filing and review of limited death benefit policy forms which will:

1. Make life insurance available to people who are otherwise uninsurable;

2. Assure that limited death policies are not sold by agents in preference to full death benefit policies and that the applicant understands that he or she may qualify for a full death benefit policy;

3. Reduce through disclosure the likelihood of misunderstanding arising where the sales presentation emphasizes the underwriting feature while minimizing or ignoring the limitation on death benefits at early durations; and

4. Set standards for the advertising of limited death benefit policy forms so as to eliminate unfair, misleading or deceptive advertising practices.

(b) This subchapter shall apply to all life insurance policy forms delivered or issued for delivery after the operative date hereof that limit death benefits during a period following the inception of the policy as an alternative to underwriting. The requirements in this subchapter apply to all previously filed forms as well as any forms submitted in the future. Previously filed forms which do not comply with these requirements are considered withdrawn as of the operative date of this subchapter.

11:4–21.2 Definitions

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

"Advertising" means any advertising materials and sales presentations in the following categories:

1. Printed and published material, audiovisual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio and television scripts, billboards and similar displays;

2. Descriptive literature and sales aids of all kinds issued by an insurer or agent, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters;

3. Material used for the recruitment, training and education of an insurer's sales personnel, agents, solicitors, and brokers which is designed to be used or used to induce the public to purchase, increase, modify, reinstate, or retain a policy; and

4. Prepared sales talks, presentations and material for use by sales personnel, agents, solicitors and brokers.

"Department" means the New Jersey Department of Insurance.

"Full death benefit policy" means any individual life insurance policy, group life insurance policy, group life insurance certificate, or fraternal benefit society certificate delivered or issued for delivery in this State which provides the full face amount as the death benefit at all times following the inception date of the policy.

"Limited death benefit policy" means any individual life insurance policy, group life insurance policy, group life insurance certificate, or fraternal benefit society certificate delivered or issued for delivery in this State which limits death benefits during a period following the inception date of the policy as an alternative to underwriting.

11:4–21.3 General requirements

(a) No limited death benefit policy shall be issued in this State unless the insurer has, at the time of application, obtained from the applicant a signed and dated statement attesting that the applicant understands that he or she may qualify for a full death benefit policy which provides full benefits from inception. A copy of this statement must be submitted to the Department for review prior to its use.

(b) All advertising of a limited death benefit policy and any revisions to the advertising must be submitted to the Department prior to use. The material submitted must include a narrative statement of the method by which the policy will be sold.

(c) All advertising for a limited death benefit policy shall prominently explain the nature of the limited death benefit policy and state the duration of the limited death benefit period.

(d) Any advertising of a limited death benefit policy which makes reference to a specific premium rate must provide:

1. For other than radio and television, a listing of the rates and benefits for all available ages (male and female); and

2. For radio and television, instructions in the procedure to be followed by the applicant to learn what benefits and rates are available.

(e) When sold by agents, the commission may not be greater on the sale of limited death benefit policies than on the sale of full death benefit policies.

(f) The limited death benefit shall not be less than the amount of premiums paid with interest at the rate used to determine nonforfeiture values under the policy.

(g) The period during which a limited death benefit applies shall not exceed 25 percent of life expectancy at the issue age, as determined by the mortality table used for nonforfeiture values under the policy, or two years, whichever is shorter.

(h) The face or ultimate amount of insurance shall not exceed $15,000.

(i) The issue age shall not be less than 45.

(j) The policy shall include a provision allowing for the return of the policy for a full refund of premiums within 30 days after delivery.

11:4–21.4 Severability

If any provision of this subchapter, or its application to any person or circumstances, is held invalid, the remainder of this subchapter and its application to other persons or circumstances shall not be affected.

SUBCHAPTER 22. INDIVIDUAL LIFE INSURANCE: USE OF GENDER BLENDED MORTALITY TABLES

Subchapter Historical Note

Subchapter 22 was adopted as R.1984 d.478, effective November 5, 1984. See: 16 N.J.R. 1452(a), 16 N.J.R. 3040(a).

11:4–22.1 Purpose

The purpose of this subchapter is to permit individual life insurance policies to provide the same cash surrender values and paid-up nonforfeiture benefits to both men and women. No change in minimum valuation standards is intended by these rules.

11:4–22.2 Definitions

The following words and terms when used in this subchapter shall have the following meanings:

"1980 CSO Table, with or without Ten Year Select Mortality Factors" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 National Association of Insurance Commissioners (NAIC) Amendments to the Model Standard Valuation Law and Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioner's 1980 Standard Ordinary Mortality Table, with or without Ten–Year Select Mortality Factors.

"1980 CSO Table (M), with or without Ten–Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for male lives from the 1980 CSO Table, with or without Ten–Year Select Mortality Factors.

"1980 CSO Table (F), with or without Ten–Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for female lives from the 1980 CSO Table, with or without Ten–Year Select Mortality Factors.

"1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioner's 1980 Extended Term Insurance Table.

"1980 CET Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 1980 CET Table.

"1980 CET Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 1980 CET Table.

"1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables" mean the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the 1980 CSO and 1980 CET Mortality Tables by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and adopted by the NAIC in December 1983.

Amended by R.1987 d.394, effective October 5, 1987.
See: 19 N.J.R. 1399(a), 19 N.J.R. 1814(a).
Added definition "1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables".

11:4–22.3 Construction of gender blended tables for use in the determination of minimum nonforfeiture benefits and minimum reserves

(a) For any policy of insurance on the life of either a male or female insured delivered or issued for delivery in this State after September 11, 1981, a life insurer which has elected or which elects an operative date under N.J.S.A. 17B:25–19h(xi) may file with the Department of Insurance for use as part of the policy form, the approved gender blended mortality tables as described in (b) below and attached as the Appendix to this subchapter, or a description thereof, to determine minimum cash surrender values and minimum amounts and minimum periods of paid-up nonforfeiture benefits.

1. An approved mortality table which is a blend of the 1980 CSO Table (M) and the 1980 CSO Table (F) with or without Ten–Year Select Mortality Factors may at the option of the company be substituted for the 1980 CSO Table, with or without our Ten–Year Select Mortality Factors; and

2. A mortality table which is of the same blend as used in (*l*) but applied to form a blend of the 1980 CET Table (M) and the 1980 CET Table (F) may at the option of the company be substituted for the 1980 CET Table.

(b) The following describes the gender blended tables approved for use pursuant to N.J.S.A. 17B:25–19h(viii). These tables are contained in the Appendix to this subchapter and are part of this proposal:

1. 100 percent Male 0 percent Female for tables to be designated as the "1980 CSO–A" and "1989 CET–A" tables;

2. 80 percent Male 20 percent Female for tables to be designated as the "1980 CSO–B" and "1980 CET–B" tables;

3. 60 percent Male 40 percent Female for tables to be designated as the "1980 CSO–C" and "1980 CET–C" tables;

4. 50 percent Male 50 percent Female for tables to be designated as the "1980 CSO–D" and "1980 CET–D" tables;

5. 40 percent Male 60 percent Female for tables to be designated as the "1980 CSO–E" and "1980 CET–E" tables;

6. 20 percent Male 80 percent Female for tables to be designated as the "1980 CSO–F" and "1980 CET–F" tables;

7. 0 percent Male 100 percent Female for tables to be designated as the "1980 CSO–G" and "1980 CET–G" tables.

(c) The tables described in paragraphs 1 and 7 of (b) above are not to be used with respect to policies issued on or after January 1, 1986, except where the proportion of persons insured is anticipated to be 90 percent or more of one sex or the other.

(d) Gender blended tables with Ten–Year Select Mortality Factors may be derived by applying select factors to gender blended tables without select factors where the select factors are derived by using the following formula:

$$ {}^{Z}F_t^T = \frac{(Z)F_t^M + .6(1\text{-}Z)\,F_t^F}{Z \quad + .6(1\text{-}Z)} $$

where

${}^{Z}F^T$ is the gender blended select factor for year t

F_t^M is the male select factor for year t

F_t^F is the female select factor for year t

Z is the ratio of male lives to the total lives at the pivotal age

11:4–22.4 Construction of Gender Blended Smoker and Nonsmoker Mortality Tables for use in the determination of minimum nonforfeiture benefits and minimum reserves

(a) In determining minimum cash surrender values, and amounts of paid up nonforfeiture benefits for any policy of insurance on the life of either a male or female insured on a form of insurance with separate rates for smokers and nonsmokers delivered or issued for delivery in this State after the operative date of N.J.S.A. 17B:25–19h(xi) for that policy form in addition to the mortality tables that may be used according to N.J.A.C. 11:4–22.3:

1. A mortality table which is a blend of the male and female rates of mortality according to the 1980 CSO Smoker Mortality Table, in the case of lives classified as smokers, or the 1980 CSO Nonsmoker Mortality Table, in the case of lives classified as nonsmokers, with or without Ten-year Select Mortality Factors, may at the option of the company be substituted for the 1980 CSO Table, with or without Ten–Year Select Mortality Factors; and

2. A mortality table which is of the same blend as used in (a)1 above but applied to form a blend of the male and female rates of mortality according to the corresponding 1980 CET Smoker Mortality Table or 1980 CET Nonsmoker Mortality Table may at the option of the company be substituted for the 1980 CET Table.

(b) The following describes the blended Smoker and Nonsmoker Mortality Tables. The tables are contained in Appendix B to this subchapter.

1. 100 percent Male 0 percent Female smoker tables designated as "1980 CSO–SA" and "1980 CET–SA" Tables.

2. 80 percent Male 20 percent Female smoker tables designated as "1980 CSO–SB" and "1980 CET–SB" Tables.

3. 60 percent Male 40 percent Female smoker tables designated as "1980 CSO–SC" and "1980 CET–SC" Tables.

4. 50 percent Male 50 percent Female smoker tables designated as "1980 CSO–SD" and "1980 CET–SD" Tables.

5. 40 percent Male 60 percent Female smoker tables designated as "1980 CSO–SE" and "1980 CET–SE" Tables.

6. 20 percent Male 80 percent Female smoker tables designated as "1980 CSO–SF" and "1980 CET–SF" Tables.

7. 0 percent Male 100 percent Female smoker tables designated as "1980 CSO–SG" and "1980 CET–SG" Tables.

8. 100 percent Male 0 percent Female nonsmoker tables designated as "1980 CSO–NA" and "1980 CET–NA" Tables.

9. 80 percent Male 20 percent Female nonsmoker tables designated as "1980 CSO–NB" and "1980 CET–NB" Tables.

10. 60 percent Male 40 percent Female nonsmoker tables designated as "1980 CSO–NC" and "1980 CET–NC" Tables.

11. 50 percent Male 50 percent Female nonsmoker tables designated as "1980 CSO–ND" and "1980 CET–ND" Tables.

12. 40 percent Male 60 percent Female nonsmoker tables designated as "1980 CSO–NE" and "1980 CET–NE" Tables.

13. 20 percent Male 80 percent Female nonsmoker tables designated as "1980 CSO–NF" and "1980 CET–NF" Tables.

14. 0 percent Male 100 percent Female nonsmoker tables designated as "1980 CSO–NG" and "1980 CET–NG" Tables.

(c) The tables described in (b)1, 7, 8 and 14 above are not acceptable as blended tables, except where the proportion of persons insured is anticipated to be 90 percent or more of one sex or the other.

11:4–22.5 Unfair discrimination

It shall not be a violation of N.J.S.A. 17B:30–12c. for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

Recodified: This section was 11:4–22.4.
See: 19 N.J.R. 1399(a), 19 N.J.R. 1814(a).

11:4–22.6 Separability

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

Recodified: This section was 11:4–22.5.
See: 19 N.J.R. 1399(a), 19 N.J.R. 1814(a).

APPENDIX A

TABLE 1
1980 CSO–A AND 1980 CET–A MORTALITY TABLES BASED ON BLENDING 1980 CSO AND 1980 CET MORTALITY TABLES 100 PERCENT MALE— PERCENT FEMALE
RATES OF MORTALITY
1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO–A	1980 CET–A
0	4.18	5.43
1	1.07	1.82
2	0.99	1.74
3	0.98	1.73
4	0.95	1.70
5	0.90	1.65
6	0.86	1.61
7	0.80	1.55
8	0.76	1.51
9	0.74	1.49
10	0.73	1.48
11	0.77	1.52
12	0.85	1.60
13	0.99	1.74
14	1.15	1.90
15	1.33	2.08
16	1.51	2.26
17	1.67	2.42
18	1.78	2.53
19	1.86	2.61
20	1.90	2.65
21	1.91	2.66
22	1.89	2.64
23	1.86	2.61
24	1.82	2.57
25	1.77	2.52
26	1.73	2.48
27	1.71	2.46

Age (x)	1980 CSO–A	1980 CET–A
28	1.70	2.45
29	1.71	2.46
30	1.73	2.48
31	1.78	2.53
32	1.83	2.58
33	1.91	2.66
34	2.00	2.75
35	2.11	2.86
36	2.24	2.99
37	2.40	3.15
38	2.58	3.35
39	2.79	3.63
40	3.02	3.93
41	3.29	4.28
42	3.56	4.63
43	3.87	5.03
44	4.19	5.45
45	4.55	5.92
46	4.92	6.40
47	5.32	6.92
48	5.74	7.46
49	6.21	8.07
50	6.71	8.72
51	7.30	9.49
52	7.96	10.35
53	8.71	11.32
54	9.56	12.43
55	10.47	13.61
56	11.46	14.90
57	12.49	16.24
58	13.59	17.67
59	14.77	19.20
60	16.08	20.90
61	17.54	22.80
62	19.19	24.95
63	21.06	27.38
64	23.14	30.08
65	25.42	33.05
66	27.85	36.21
67	30.44	39.57
68	33.19	43.15
69	36.17	47.02
70	39.51	51.36
71	43.30	56.29
72	47.65	61.95
73	52.64	68.43
74	58.19	75.65
75	64.19	83.45
76	70.53	91.69
77	77.12	100.26
78	83.90	109.07
79	91.05	118.37
80	98.84	128.49
81	107.48	139.72
82	117.25	152.43
83	128.26	166.74
84	140.25	182.33
85	152.95	198.84
86	166.09	215.92
87	179.55	233.42
88	193.27	251.25
89	207.29	269.48
90	221.77	288.30
91	236.98	308.07
92	253.45	329.49
93	272.11	353.74
94	295.90	384.67
95	329.96	428.95
96	384.55	499.92
97	480.20	624.26
98	657.98	855.37
99	1000.00	1000.00

TABLE 2
1980 CSO–B AND 1980 CET–B MORTALITY TABLES BASED ON BLENDING 1980 CSO AND 1980 CET MORTALITY TABLES 80 PERCENT MALE—20 PERCENT FEMALE
(PIVOTAL AGE 45)
RATES OF MORTALITY
1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO–B	1980 CET–B
0	3.92	5.10
1	1.04	1.79
2	.95	1.70
3	.94	1.69
4	.91	1.66
5	.87	1.62
6	.83	1.58
7	.79	1.54
8	.75	1.50
9	.73	1.48
10	.72	1.47
11	.75	1.50
12	.83	1.58
13	.94	1.69
14	1.08	1.83
15	1.24	1.99
16	1.39	2.14
17	1.53	2.28
18	1.62	2.37
19	1.69	2.44
20	1.74	2.49
21	1.75	2.50
22	1.73	2.48
23	1.71	2.46
24	1.69	2.44

Age (x)	1980 CSO–B	1980 CET–B
25	1.65	2.40
26	1.63	2.38
27	1.61	2.36
28	1.61	2.36
29	1.63	2.38
30	1.65	2.40
31	1.70	2.45
32	1.75	2.50
33	1.83	2.58
34	1.91	2.66
35	2.02	2.77
36	2.14	2.89
37	2.30	3.05
38	2.47	3.22
39	2.68	3.48
40	2.90	3.77
41	3.16	4.11
42	3.42	4.45
43	3.72	4.84
44	4.01	5.21
45	4.35	5.66
46	4.70	6.11
47	5.07	6.59
48	5.45	7.09
49	5.89	7.66
50	6.36	8.27
51	6.90	8.97
52	7.50	9.75
53	8.19	10.65
54	8.96	11.65
55	9.78	12.71
56	10.67	13.87
57	11.58	15.05
58	12.54	16.30
59	13.57	17.64
60	14.72	19.14
61	16.00	20.80
62	17.47	22.71
63	19.16	24.91
64	21.05	27.37
65	23.11	30.04
66	25.29	32.88
67	27.61	35.89
68	30.03	39.04
69	32.66	42.46
70	35.59	46.27
71	38.95	50.64
72	42.84	55.69
73	47.33	61.53
74	52.37	68.08
75	57.84	75.19
76	63.65	82.75
77	69.70	90.61
78	75.95	98.74
79	82.57	107.34
80	89.83	116.78
81	97.94	127.32
82	107.18	139.33
83	117.65	152.95
84	129.10	167.83
85	141.38	183.79
86	154.17	200.42
87	167.49	217.74
88	181.24	235.61
89	195.54	254.20
90	210.53	273.69
91	226.51	294.46
92	244.13	317.37
93	264.04	343.25
94	289.36	376.17
95	324.89	422.36
96	380.97	495.26
97	477.69	621.00
98	657.38	854.59
99	1000.00	1000.00

TABLE 3
1980 CSO–C AND 1980 CET–C MORTALITY TABLES BASED ON BLENDING 1980 CSO AND 1980 CET MORTALITY TABLES 60 PERCENT MALE—40 PERCENT FEMALE
(PIVOTAL AGE 45)
RATES OF MORTALITY
1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO–C	1980 CET–C
0	3.67	4.77
1	.99	1.74
2	.93	1.68
3	.90	1.65
4	.88	1.63
5	.84	1.59
6	.81	1.56
7	.77	1.52
8	.73	1.48
9	.73	1.48
10	.71	1.46
11	.74	1.49
12	.80	1.55
13	.89	1.64
14	1.01	1.76
15	1.14	1.89
16	1.27	2.02
17	1.38	2.13
18	1.47	2.22
19	1.52	2.27
20	1.56	2.31

Age (x)	1980 CSO–C	1980 CET–C
21	1.58	2.33
22	1.58	2.33
23	1.56	2.31
24	1.55	2.30
25	1.53	2.28
26	1.52	2.27
27	1.51	2.26
28	1.53	2.28
29	1.54	2.29
30	1.58	2.33
31	1.63	2.38
32	1.67	2.42
33	1.75	2.50
34	1.83	2.58
35	1.93	2.68
36	2.04	2.79
37	2.20	2.95
38	2.36	3.11
39	2.56	3.33
40	2.78	3.61
41	3.03	3.94
42	3.29	4.28
43	3.56	4.63
44	3.84	4.99
45	4.15	5.40
46	4.47	5.81
47	4.81	6.25
48	5.17	6.72
49	5.58	7.25
50	6.01	7.81
51	6.50	8.45
52	7.05	9.17
53	7.68	9.98
54	8.37	10.88
55	9.11	11.84
56	9.88	12.84
57	10.68	13.88
58	11.50	14.95
59	12.39	16.11
60	13.37	17.38
61	14.48	18.81
62	15.79	20.53
63	17.30	22.49
64	19.01	24.71
65	20.88	27.14
66	22.84	29.69
67	24.90	32.37
68	27.04	35.15
69	29.32	38.12
70	31.92	41.50
71	34.90	45.37
72	38.38	49.89
73	42.48	55.22
74	47.11	61.24
75	52.16	67.81
76	57.58	74.85
77	63.24	82.21
78	69.13	89.87
79	75.41	98.03
80	82.34	107.04
81	90.17	117.22
82	99.12	128.86
83	109.33	142.13
84	120.58	156.75
85	132.68	172.48
86	145.47	189.11
87	158.84	206.49
88	172.87	224.73
89	187.54	243.80
90	203.08	264.00
91	219.76	285.69
92	238.20	309.66
93	259.26	337.04
94	285.17	370.72
95	322.03	418.64
96	378.56	492.14
97	476.70	619.71
98	657.10	854.23
99	1000.00	1000.00

TABLE 4
1980 CSO–D AND 1980 CET–D MORTALITY TABLES BASED ON BLENDING 1980 CSO AND 1980 CET MORTALITY TABLES 50 PERCENT MALE—50 PERCENT FEMALE
(PIVOTAL AGE 45)
RATES OF MORTALITY
1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO–D	1980 CET–D
0	3.54	4.60
1	.97	1.72
2	.91	1.66
3	.89	1.64
4	.85	1.60
5	.83	1.58
6	.79	1.54
7	.77	1.52
8	.73	1.48
9	.72	1.47
10	.71	1.46
11	.72	1.47
12	.78	1.53
13	.87	1.62
14	.97	1.72
15	1.10	1.85
16	1.21	1.96
17	1.31	2.06

Age (x)	1980 CSO-D	1980 CET-D
18	1.39	2.14
19	1.44	2.19
20	1.48	2.23
21	1.49	2.24
22	1.50	2.25
23	1.49	2.24
24	1.49	2.24
25	1.47	2.22
26	1.47	2.22
27	1.46	2.21
28	1.48	2.23
29	1.51	2.26
30	1.54	2.29
31	1.58	2.33
32	1.64	2.39
33	1.70	2.45
34	1.79	2.54
35	1.88	2.63
36	2.00	2.75
37	2.14	2.89
38	2.31	3.06
39	2.51	3.26
40	2.72	3.54
41	2.97	3.86
42	3.22	4.19
43	3.49	4.54
44	3.75	4.88
45	4.06	5.28
46	4.36	5.67
47	4.68	6.08
48	5.03	6.54
49	5.41	7.03
50	5.83	7.58
51	6.30	8.19
52	6.82	8.87
53	7.42	9.65
54	8.07	10.49
55	8.77	11.40
56	9.50	12.35
57	10.23	13.30
58	10.99	14.29
59	11.81	15.35
60	12.71	16.52
61	13.75	17.88
62	14.96	19.45
63	16.39	21.31
64	18.02	23.43
65	19.78	25.71
66	21.64	28.13
67	23.59	30.67
68	25.58	33.25
69	27.73	36.05
70	30.16	39.21
71	32.96	42.85
72	36.29	47.18
73	40.20	52.26
74	44.66	58.06
75	49.55	64.42
76	54.80	71.24
77	60.31	78.40
78	66.06	85.88
79	72.23	93.90
80	79.07	102.79
81	86.80	112.84
82	95.68	124.38
83	105.81	137.55
84	117.02	152.13
85	129.11	167.84
86	141.91	184.48
87	155.41	202.03
88	169.55	220.42
89	184.45	239.79
90	200.23	260.30
91	217.23	282.40
92	235.91	306.68
93	257.43	334.66
94	283.81	368.95
95	320.74	416.96
96	377.93	491.31
97	476.61	619.59
98	656.44	853.37
99	1000.00	1000.00

TABLE 5
1980 CSO-E AND 1980 CET-E MORTALITY TABLES BASED ON BLENDING 1980 CSO AND 1980 CET MORTALITY TABLES 40 PERCENT MALE—60 PERCENT FEMALE
(PIVOTAL AGE 45)
RATES OF MORTALITY
1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO-E	1980 CET-E
0	3.41	4.43
1	.95	1.70
2	.89	1.64
3	.86	1.61
4	.84	1.59
5	.81	1.56
6	.78	1.53
7	.76	1.51
8	.72	1.47
9	.71	1.46
10	.70	1.45
11	.71	1.46
12	.77	1.52
13	.84	1.59
14	.94	1.69

Age (x)	1980 CSO–E	1980 CET–E
15	1.05	1.80
16	1.15	1.90
17	1.24	1.99
18	1.31	2.06
19	1.36	2.11
20	1.39	2.14
21	1.41	2.16
22	1.42	2.17
23	1.42	2.17
24	1.42	2.17
25	1.40	2.15
26	1.41	2.16
27	1.42	2.17
28	1.44	2.19
29	1.46	2.21
30	1.50	2.25
31	1.55	2.30
32	1.60	2.35
33	1.66	2.41
34	1.75	2.50
35	1.83	2.58
36	1.95	2.70
37	2.09	2.84
38	2.25	3.00
39	2.45	3.20
40	2.66	3.46
41	2.90	3.77
42	3.15	4.10
43	3.41	4.43
44	3.66	4.76
45	3.96	5.15
46	4.24	5.51
47	4.55	5.92
48	4.89	6.36
49	5.26	6.84
50	5.66	7.36
51	6.10	7.93
52	6.60	8.58
53	7.16	9.31
54	7.77	10.10
55	8.43	10.96
56	9.11	11.84
57	9.79	12.73
58	10.48	13.62
59	11.23	14.60
60	12.05	15.67
61	13.01	16.91
62	14.14	18.38
63	15.50	20.15
64	17.03	22.14
65	18.71	24.32
66	20.46	26.60
67	22.31	29.00
68	24.17	31.42
69	26.18	34.03
70	28.45	36.99
71	31.10	40.43
72	34.27	44.55
73	38.02	49.43
74	42.32	55.02
75	47.05	61.17
76	52.18	67.83
77	57.57	74.84
78	63.21	82.17
79	69.29	90.08
80	76.04	98.85
81	83.72	108.84
82	92.52	120.28
83	102.65	133.45
84	113.82	147.97
85	125.93	163.71
86	138.78	180.41
87	152.39	198.11
88	166.68	216.68
89	181.76	236.29
90	197.78	257.11
91	215.12	279.66
92	234.03	304.24
93	255.85	332.61
94	282.58	367.35
95	319.76	415.69
96	377.41	490.63
97	476.21	619.07
98	656.10	852.93
99	1000.00	1000.00

TABLE 6
1980 CSO–F AND 1980 CET–F MORTALITY TABLES
BASED ON BLENDING 1980 CSO AND 1980 CET
MORTALITY TABLES 20 PERCENT MALE—
80 PERCENT FEMALE
(PIVOTAL AGE 45)
RATES OF MORTALITY
1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO–F	1980 CET–F
0	3.15	4.10
1	.92	1.67
2	.85	1.60
3	.82	1.57
4	.81	1.56
5	.79	1.54
6	.76	1.51
7	.74	1.49
8	.71	1.46
9	.70	1.45
10	.70	1.45

Age (x)	1980 CSO-F	1980 CET-F
11	.70	1.45
12	.74	1.49
13	.80	1.55
14	.86	1.61
15	.95	1.70
16	1.03	1.78
17	1.09	1.84
18	1.15	1.90
19	1.19	1.94
20	1.22	1.97
21	1.24	1.99
22	1.25	2.00
23	1.27	2.02
24	1.28	2.03
25	1.29	2.04
26	1.30	2.05
27	1.31	2.06
28	1.35	2.10
29	1.38	2.13
30	1.42	2.17
31	1.47	2.22
32	1.52	2.27
33	1.58	2.33
34	1.66	2.41
35	1.74	2.49
36	1.85	2.60
37	1.99	2.74
38	2.15	2.90
39	2.32	3.07
40	2.54	3.30
41	2.77	3.60
42	3.02	3.93
43	3.25	4.23
44	3.49	5.54
45	3.75	4.88
46	4.02	5.23
47	4.30	5.59
48	4.61	5.99
49	4.94	6.42
50	5.31	6.90
51	5.70	7.41
52	6.15	8.00
53	6.65	8.65
54	7.19	9.35
55	7.76	10.09
56	8.34	10.84
57	8.91	11.58
58	9.47	12.31
59	10.08	13.10
60	10.75	13.98
61	11.55	15.02
62	12.54	16.30
63	13.74	17.86
64	15.10	19.63
65	16.62	12.61
66	18.19	23.65
67	19.81	25.75
68	21.45	27.89
69	23.19	30.15
70	25.19	32.75
71	27.57	35.84
72	30.43	39.56
73	33.92	44.10
74	37.94	49.32
75	42.43	55.16
76	47.33	61.53
77	52.53	68.29
78	58.03	75.44
79	63.98	83.17
80	70.65	91.85
81	78.26	101.74
82	87.04	113.15
83	97.15	126.30
84	108.33	140.83
85	120.52	156.68
86	133.53	173.59
87	147.37	191.58
88	161.93	210.51
89	177.40	230.62
90	193.80	251.94
91	211.61	275.09
92	231.05	300.37
93	253.44	329.47
94	280.66	364.86
95	318.37	413.88
96	376.21	489.07
97	475.72	618.44
98	656.09	852.92
99	1000.00	1000.00

TABLE 7
1980 CSO-G AND 1980 CET-G MORTALITY TABLES BASED ON BLENDING 1980 CSO AND 1980 CET MORTALITY TABLES 0 PERCENT MALE—100 PERCENT FEMALE

RATES OF MORTALITY
1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO-G	1980 CET-G
0	2.89	3.76
1	.87	1.62
2	.81	1.56
3	.79	1.54
4	.77	1.52
5	.76	1.51
6	.73	1.48
7	.72	1.47
8	.70	1.45

Age (x)	1980 CSO–G	1980 CET–G
9	.69	1.44
10	.68	1.43
11	.69	1.44
12	.72	1.47
13	.75	1.50
14	.80	1.55
15	.85	1.60
16	.90	1.65
17	.95	1.70
18	.98	1.73
19	1.02	1.77
20	1.05	1.80
21	1.07	1.82
22	1.09	1.84
23	1.11	1.86
24	1.14	1.89
25	1.16	1.91
26	1.19	1.94
27	1.22	1.97
28	1.26	2.01
29	1.30	2.05
30	1.35	2.10
31	1.40	2.15
32	1.45	2.20
33	1.50	2.25
34	1.58	2.33
35	1.65	2.40
36	1.76	2.51
37	1.89	2.64
38	2.04	2.79
39	2.22	2.97
40	2.42	3.17
41	2.64	3.43
42	2.87	3.73
43	3.09	4.02
44	3.32	4.32
45	3.56	4.63
46	3.80	4.94
47	4.05	5.27
48	4.33	5.63
49	4.63	6.02
50	4.96	6.45
51	5.31	6.90
52	5.70	7.41
53	6.15	8.00
54	6.61	8.59
55	7.09	9.22
56	7.57	9.84
57	8.03	10.44
58	8.47	11.01
59	8.94	11.62
60	9.47	12.31
61	10.13	13.17
62	10.96	14.25
63	12.02	15.63
64	13.25	17.23
65	14.59	18.97
66	16.00	20.80
67	17.43	22.66
68	18.84	24.49
69	20.36	26.47
70	22.11	28.74
71	24.23	31.50
72	26.87	34.93
73	30.11	39.14
74	33.93	44.11
75	38.24	49.71
76	42.97	55.86
77	48.04	62.45
78	53.45	69.49
79	59.35	77.16
80	65.99	85.79
81	73.60	95.68
82	82.40	107.12
83	92.53	120.29
84	103.81	134.95
85	116.10	150.93
86	129.29	168.08
87	143.32	186.32
88	158.18	205.63
89	173.94	226.12
90	190.75	247.98
91	208.87	271.53
92	228.81	297.45
93	251.51	326.96
94	279.31	363.10
95	317.32	412.52
96	375.74	488.46
97	474.97	617.46
98	655.85	852.61
99	1000.00	1000.00

APPENDIX B

1980 CSO–SA Smoker Table 1

Age	Non–Smoker	Smoker
15	1.29	1.65
16	1.43	1.87
17	1.54	2.05
18	1.60	2.16
19	1.66	2.26
20	1.63	2.31
21	1.67	2.33
22	1.64	2.30
23	1.61	2.26
24	1.57	2.21
25	1.52	2.14
26	1.48	2.08
27	1.46	2.06

Age	Non-Smoker	Smoker
28	1.44	2.04
29	1.44	2.06
30	1.44	2.10
31	1.47	2.17
32	1.50	2.24
33	1.55	2.35
34	1.61	2.48
35	1.69	2.63
36	1.77	2.81
37	1.88	3.04
38	2.00	3.30
39	2.14	3.60
40	2.29	3.94
41	2.47	4.34
42	2.65	4.75
43	2.86	5.22
44	3.07	5.71
45	3.32	6.27
46	3.59	6.83
47	3.88	7.44
48	4.19	8.08
49	4.54	8.80
50	4.91	9.50
51	5.35	10.44
52	5.86	11.42
53	6.43	12.54
54	7.09	13.80
55	7.82	15.14
56	8.63	16.59
57	9.49	18.09
58	10.42	19.69
59	11.47	21.35
60	12.64	23.19
61	13.94	25.26
62	15.42	27.59
63	17.11	30.23
64	19.02	33.14
65	21.13	36.29
66	23.40	39.57
67	25.86	43.01
68	23.50	46.55
69	31.38	50.32
70	34.63	54.48
71	88.91	59.09
72	42.56	64.33
73	47.44	70.23
74	52.92	76.66
75	58.80	83.77
76	65.06	91.10
77	71.64	98.52
78	78.47	105.91
79	85.72	113.49
80	93.67	121.59
81	102.52	130.41
82	112.52	140.20
83	123.79	151.03
84	136.11	162.49
85	149.20	174.20
86	162.80	185.78
87	176.79	197.06
88	190.89	209.37
89	205.29	221.52
90	220.19	233.69
91	235.84	246.12
92	252.75	259.33
93	271.63	276.30
94	295.65	298.15
95	329.96	329.96
96	384.55	384.55
97	480.20	480.20
98	657.98	657.98
99	1000.00	1000.00

1980 CSO–NA Nonsmoker Table 2

Age	Non-Smoker	Smoker
15	1.29	1.65
16	1.43	1.87
17	1.54	2.05
18	1.60	2.16
19	1.66	2.26
20	1.63	2.31
21	1.67	2.33
22	1.64	2.30
23	1.61	2.26
24	1.57	2.21
25	1.52	2.14
26	1.48	2.08
27	1.46	2.06
28	1.44	2.04
29	1.44	2.06
30	1.44	2.10
31	1.47	2.17
32	1.50	2.24
33	1.55	2.35
34	1.61	2.48
35	1.69	2.63
36	1.77	2.81
37	1.88	3.04
38	2.00	3.30
39	2.14	3.60
40	2.29	3.94
41	2.47	4.34
42	2.65	4.75
43	2.86	5.22
44	3.07	5.71
45	3.32	6.27
46	3.59	6.83
47	3.88	7.44
48	4.19	8.08
49	4.54	8.80
50	4.91	9.50
51	5.35	10.44
52	5.86	11.42
53	6.43	12.54
54	7.09	13.80
55	7.82	15.14
56	8.63	16.59
57	9.49	18.09
58	10.42	19.69
59	11.47	21.35
60	12.64	23.19
61	13.94	25.26
62	15.42	27.59
63	17.11	30.23
64	19.02	33.14
65	21.13	36.29
66	23.40	39.57

Age	Non-Smoker	Smoker
67	25.86	43.01
68	23.50	46.55
69	31.38	50.32
70	34.63	54.48
71	88.91	59.09
72	42.56	64.33
73	47.44	70.23
74	52.92	76.66
75	58.80	83.77
76	65.06	91.10
77	71.64	98.52
78	78.47	105.91
79	85.72	113.49
80	93.67	121.59
81	102.52	130.41
82	112.52	140.20
83	123.79	151.03
84	136.11	162.49
85	149.20	174.20
86	162.80	185.78
87	176.79	197.06
88	190.89	209.37
89	205.29	221.52
90	220.19	233.69
91	235.84	246.12
92	252.75	259.33
93	271.63	276.30
94	295.65	298.15
95	329.96	329.96
96	384.55	384.55
97	480.20	480.20
98	657.98	657.98
99	1000.00	1000.00

1980 CET–SA Smoker Table 3

Age	Non-Smoker	Smoker
15	2.11	2.51
16	2.23	2.71
17	2.32	2.85
18	2.38	2.96
19	2.42	3.03
20	2.43	3.07
21	2.41	3.07
22	2.38	3.03
23	2.34	2.99
24	2.30	2.93
25	2.25	2.86
26	2.22	2.82
27	2.20	2.80
28	2.19	2.80
29	2.19	2.83
30	2.20	2.88
31	2.23	2.95
32	2.27	3.04
33	2.33	3.16
34	2.40	3.32
35	2.48	3.54
36	2.57	3.80
37	2.69	4.12
38	2.82	4.49
39	2.96	4.90
40	2.13	5.38
41	3.33	5.90
42	3.58	6.47
43	3.85	7.10
44	4.15	7.79
45	4.49	8.52
46	4.85	9.27
47	5.24	10.09
48	5.67	10.97
49	6.14	11.93
50	6.67	13.00
51	7.28	14.21
52	7.98	15.57
53	8.79	17.12
54	9.69	18.81
55	10.69	20.62
56	11.78	22.53
57	12.94	24.54
58	14.22	26.66
59	15.67	28.94
60	17.28	31.47
61	19.07	34.33
62	21.14	37.56
63	23.48	41.16
64	26.08	45.10
65	28.93	49.27
66	32.01	53.64
67	25.31	58.16
68	38.90	62.91
69	42.87	68.06
70	47.37	73.74
71	52.51	80.12
72	58.44	87.33
73	65.14	95.33
74	72.51	104.09
75	80.39	113.45
76	88.71	123.02
77	97.41	132.63
78	106.54	142.34
79	116.38	152.49
80	127.24	163.42
81	139.43	175.45
82	153.17	188.77
83	168.40	203.18
84	184.83	218.18
85	202.00	233.27
86	219.93	248.09
87	238.11	263.80
88	256.53	279.15
89	275.46	294.91
90	295.17	310.80
91	316.11	327.34
92	339.07	346.52
93	366.28	371.11
94	402.78	404.65
95	457.42	457.42
96	547.29	547.29
97	703.30	703.30
98	968.70	968.70
99	1000.00	1000.00

1980 CET–NA Non–Smoker Table 4

Age	Non-Smoker	Smoker
15	2.11	2.51

Age	Non-Smoker	Smoker
16	2.23	2.71
17	2.32	2.85
18	2.38	2.96
19	2.42	3.03
20	2.43	3.07
21	2.41	3.07
22	2.38	3.03
23	2.34	2.99
24	2.30	2.93
25	2.25	2.86
26	2.22	2.82
27	2.20	2.80
28	2.19	2.80
29	2.19	2.83
30	2.20	2.88
31	2.23	2.95
32	2.27	3.04
33	2.33	3.16
34	2.40	3.32
35	2.48	3.54
36	2.57	3.80
37	2.69	4.12
38	2.82	4.49
39	2.96	4.90
40	2.13	5.38
41	3.33	5.90
42	3.58	6.47
43	3.85	7.10
44	4.15	7.79
45	4.49	8.52
46	4.85	9.27
47	5.24	10.09
48	5.67	10.97
49	6.14	11.93
50	6.67	13.00
51	7.28	14.21
52	7.98	15.57
53	8.79	17.12
54	9.69	18.81
55	10.69	20.62
56	11.78	22.53
57	12.94	24.54
58	14.22	26.66
59	15.67	28.94
60	17.28	31.47
61	19.07	34.33
62	21.14	37.56
63	23.48	41.16
64	26.08	45.10
65	28.93	49.27
66	32.01	53.64
67	25.31	58.16
68	38.90	62.91
69	42.87	68.06
70	47.37	73.74
71	52.51	80.12
72	58.44	87.33
73	65.14	95.33
74	72.51	104.09
75	80.39	113.45
76	88.71	123.02
77	97.41	132.63
78	106.54	142.34
79	116.38	152.49
80	127.24	163.42
81	139.43	175.45
82	153.17	188.77
83	168.40	203.18
84	184.83	218.18
85	202.00	233.27
86	219.93	248.09
87	238.11	263.80
88	256.53	279.15
89	275.46	294.91
90	295.17	310.80
91	316.11	327.34
92	339.07	346.52
93	366.28	371.11
94	402.78	404.65
95	457.42	457.42
96	547.29	547.29
97	703.30	703.30
98	968.70	968.70
99	1000.00	1000.00

1980 CSO–SB SMOKER TABLE &
1980 CET–SB SMOKER TABLE #
Pivotal Age Is 45 *** Ratio of Male 1_x to Total Is 80%
1980 CSO–SB SMOKER TABLE 5

Age	1_x	$1000q_x$
15	223083	1.51
16	222746	1.70
17	222367	1.85
18	221956	1.95
19	221523	2.04
20	221071	2.09
21	220609	2.10
22	220146	2.09
23	219686	2.06
24	219233	2.03
25	218788	1.97
26	218357	1.93
27	217936	1.92
28	217518	1.92
29	217100	1.94
30	216679	1.99
31	216248	2.06
32	215803	2.13
33	215343	2.23
34	214863	2.35
35	214358	2.50
36	213822	2.67
37	213251	2.89
38	212635	3.14
39	211967	3.43
40	211240	3.75
41	210448	4.14
42	209577	4.53
43	208628	4.97
44	207591	5.42
45	206466	5.94
46	205240	6.45
47	203916	7.01
48	202487	7.60
49	200948	8.25
50	199290	8.95
51	197506	9.74

Age	1_x	$1000q_x$
52	195582	10.63
53	193503	11.64
54	191251	12.77
55	188809	13.96
56	186173	15.24
57	183336	16.55
58	180302	17.93
59	177069	19.36
60	173641	20.93
61	170007	22.72
62	166144	24.75
63	162032	27.09
64	157643	29.66
65	152967	32.45
66	148003	35.33
67	142774	38.33
68	137301	41.34
69	131625	44.56
70	125760	48.06
71	119716	52.02
72	113488	56.56
73	107069	61.72
74	100461	67.39
75	93691	73.64
76	86792	80.11
77	79839	86.64
78	72922	93.17
79	66128	99.91
80	59521	107.14
81	53144	115.11
82	47027	124.03
83	41194	134.01
84	35674	144.97
85	30502	165.08
86	25741	167.75
87	21423	179.03
88	17588	191.74
89	14216	204.04
90	11315	217.42
91	8855	231.58
92	6804	246.88
93	5124	265.45
94	3764	*289.36
95	2675	*324.89
96	1806	*380.97
97	1118	*477.69
98	584	*657.38
99	200	1000.00

1980 CET–SB SMOKER TABLE 6

Age	1_x	$1000q_x$
15	4675331	2.26
16	4664765	2.45
17	4653336	2.60
18	4641237	2.70
19	4628706	2.79
20	4615792	2.84
21	4602683	2.85
22	4589565	2.84
23	2576531	2.81
24	4563671	2.78
25	4550984	2.72
26	4538605	2.68
27	4526442	2.67
28	4514356	2.67
29	4502303	2.69
30	4490192	2.74
31	4477889	2.81
32	4465306	2.88
33	4452446	2.98
34	4439178	3.10
35	4425417	3.25
36	4411034	3.47
37	4395728	3.76
38	4379200	4.08
39	4361333	4.46
40	4341881	4.88
41	4320693	5.38
42	4297448	5.89
43	4272136	6.46
44	4244538	7.05
45	4214614	7.72
46	4182077	8.39
47	4146989	9.11
48	4109210	9.88
49	4068611	10.73
50	4024955	11.64
51	3978105	12.66
52	3927742	13.82
53	3873461	15.13
54	3814856	16.60
55	3751529	18.15
56	3683439	19.81
57	3610470	21.52
58	3532773	23.31
59	3450424	25.17
60	3363577	27.21
61	3272054	29.54
62	3175398	32.18
63	3073214	35.22
64	2964975	38.56
65	2850646	42.19
66	2730377	45.93
67	2604971	49.83
68	2475165	53.74
69	2342150	57.93
70	2206469	62.48
71	2068609	67.63
72	1928709	73.53
73	1786891	80.24
74	1643511	87.61
75	1499523	95.73
76	1355974	104.14
77	1214763	112.63
78	1077944	121.12
79	947383	129.88
80	824337	139.28
81	709523	149.64
82	603350	161.24
83	506066	174.21
84	417904	188.46
85	339146	202.90
86	270333	218.08
87	211379	232.74
88	162183	249.26
89	121757	265.25
90	89461	282.65
91	64175	301.05
92	44855	320.94
93	30459	345.09

Age	1_x	$1000q_x$
94	19948	376.17
95	12444	422.36
96	7188	495.26
97	3628	621.00
98	1375	854.59
99	200	1000.00

Age nearest birthday CSO: Sum qx= 4770.93 Sum 1x= 12302728
* Adjusted; see text CET: Sum qx= 8674.67 Sum 1x= 242009995

1980 CSO–SC SMOKER TABLE &
1980 CET–SC SMOKER TABLE #
Pivotal Age Is 45 *** Ratio of Male 1_x to Total Is 60%
1980 CSO–SC SMOKER TABLE 7

Age	1_x	$1000q_x$
15	161242	1.37
16	161021	1.52
17	160776	1.65
18	160511	1.74
19	160232	1.82
20	159940	1.86
21	159643	1.88
22	159343	1.87
23	159045	1.85
24	158751	1.84
25	158459	1.81
26	158172	1.79
27	157889	1.79
28	157606	1.79
29	157324	1.83
30	157036	1.88
31	156741	1.95
32	156435	2.02
33	156119	2.11
34	155790	2.23
35	155443	2.35
36	155078	2.52
37	154687	2.74
38	154263	2.98
39	153803	3.25
40	153303	3.56
41	152757	3.94
42	152155	4.31
43	151499	4.71
44	150785	5.14
45	150010	5.61
46	149168	6.08
47	148261	6.59
48	147284	7.12
49	146235	7.71
50	145108	8.35
51	143896	9.05
52	142594	9.84
53	141191	10.75
54	139673	11.75
55	138032	12.80
56	136265	13.92
57	134368	15.05
58	132346	16.21
59	130201	17.41
60	127934	18.74
61	125537	20.27
62	122992	22.02
63	120284	24.08
64	117388	26.36
65	114294	28.83
66	110999	31.35
67	107519	33.97
68	103867	36.55
69	100071	39.31
70	96137	42.29
71	92071	45.73
72	87861	49.75
73	83490	54.37
74	78951	59.53
75	74251	65.21
76	69409	71.12
77	64473	77.16
78	59498	83.23
79	54546	89.55
80	49661	96.42
81	44873	104.08
82	40203	112.72
83	35671	122.47
84	31302	133.48
85	27124	144.59
86	23202	156.67
87	19567	168.41
88	16272	181.66
89	13316	194.45
90	10727	208.76
91	8488	223.98
92	6587	240.65
93	5002	260.28
94	3700	*285.17
95	2645	*322.03
96	1793	*378.56
97	1114	*476.70
98	583	*657.10
99	200	1000.00

1980 CET–SC SMOKER TABLE 8

Age	1_x	$1000q_x$
15	3003428	2.12
16	2997061	2.27
17	2990258	2.40
18	2983081	2.49
19	2975653	2.57
20	2968006	2.61
21	2960260	2.63
22	2952475	2.62
23	2944740	2.60
24	2937084	2.59
25	2929477	2.56
26	2921978	2.54
27	2914556	2.54
28	2907153	2.54
29	2899769	2.58
30	2892288	2.63
31	2884681	2.70
32	2876892	2.77
33	2868923	2.86
34	2860718	2.98
35	2852193	3.10
36	2843351	3.28
37	2834025	3.56
38	2823936	3.87
39	2813007	4.23
40	2801108	4.63
41	2788139	5.12

Age	1_x	$1000q_x$
42	2773864	5.60
43	2758330	6.12
44	2741449	6.68
45	2723136	7.29
46	2703284	7.90
47	2681928	8.57
48	2658944	9.26
49	2634322	10.02
50	2607926	10.86
51	2579604	11.77
52	2549242	12.79
53	2516637	13.98
54	2481454	15.28
55	2443537	16.64
56	2402877	18.10
57	2359385	19.57
58	2313212	21.07
59	2264473	22.63
60	2213228	24.36
61	2159314	26.35
62	2102416	28.63
63	2042224	31.30
64	1978302	34.27
65	1910506	37.48
66	1838900	40.76
67	1763946	44.16
68	1686050	47.52
69	1605929	51.10
70	1523866	54.98
71	1440084	59.45
72	1354471	64.68
73	1266864	70.68
74	1177322	77.39
75	1086209	84.77
76	994131	92.46
77	902214	100.31
78	811713	108.20
79	723886	116.42
80	639611	125.35
81	559436	135.30
82	483744	146.54
83	412856	159.21
84	347125	173.52
85	286892	187.97
86	232965	203.67
87	185517	218.93
88	144902	236.16
89	110682	252.79
90	82703	271.39
91	60258	291.17
92	42713	312.85
93	29350	338.36
94	19419	370.72
95	12220	418.64
96	7104	492.13
97	3608	619.71
98	1372	854.23
99	200	1000.00

Age nearest birthday CSO: Sum qx= 4498.38 Sum 1x= 9084082
* Adjusted; see text CET: Sum qx= 8307.43 Sum 1x= 158862096

1980 CSO–SD SMOKER TABLE &
1980 CET–SD SMOKER TABLE #
Pivotal Age is 45 *** Ratio of Male 1_x to Total Is 50%
1980 CSO–SD SMOKER TABLE 9

Age	1_x	$1000q_x$
15	141303	1.30
16	141119	1.44
17	140916	1.55
18	140698	1.63
19	140469	1.71
20	140229	1.74
21	139985	1.76
22	139739	1.76
23	139493	1.75
24	139249	1.74
25	139007	1.72
26	138768	1.71
27	138531	1.72
28	138293	1.73
29	138054	1.77
30	137810	1.82
31	137559	1.89
32	137299	1.96
33	137030	2.05
34	136749	2.17
35	136452	2.29
36	136140	2.45
37	135806	2.67
38	135443	2.90
39	135050	3.16
40	134623	3.47
41	134156	3.83
42	133642	4.20
43	133081	4.59
44	132470	4.99
45	131809	5.44
46	131092	5.89
47	130320	6.37
48	129490	6.88
49	128599	7.43
50	127644	8.04
51	126618	8.71
52	125515	9.46
53	124328	10.31
54	123046	11.25
55	121662	12.23
56	120174	13.26
57	118580	14.30
58	116884	15.36
59	115089	16.46
60	113195	17.67
61	111195	19.07
62	109075	20.69
63	106818	22.62
64	104402	24.76
65	101817	27.09
66	99059	29.46
67	96141	31.91
68	93073	34.28
69	89882	36.86
70	86569	39.60
71	83141	42.85
72	79578	46.65
73	75866	51.06
74	71992	56.02
75	67959	61.49
76	63780	67.22
77	59493	73.10
78	55144	79.03
79	50786	85.26
80	46456	92.04
81	42180	99.64

Age	1_x	$1000q_x$
82	37977	108.24
83	33866	117.99
84	29870	129.09
85	26014	140.30
86	22364	152.63
87	18951	164.55
88	15833	178.09
89	13013	191.10
90	10526	205.79
91	8360	221.41
92	6509	238.61
93	4956	258.45
94	3675	*283.81
95	2632	*320.74
96	1788	*377.93
97	1112	*476.61
98	582	*656.44
99	200	1000.00

1980 CET–SD SMOKER TABLE 10

Age	1_x	$1000q_x$
15	2503786	2.05
16	2498653	2.19
17	2493181	2.30
18	2487447	2.38
19	2481527	2.46
20	2475422	2.49
21	2469258	2.51
22	2463060	2.51
23	2456878	2.50
24	2450736	2.49
25	2444634	2.47
26	2438596	2.46
27	2432597	2.47
28	2426588	2.48
29	2420570	2.52
30	2414470	2.57
31	2408265	2.64
32	2401907	2.71
33	2395398	2.80
34	2388691	2.92
35	2381716	3.04
36	2374476	3.20
37	2366878	3.47
38	2358665	3.77
39	2349773	4.11
40	2340115	4.51
41	2329561	4.98
42	2317960	5.46
43	2305304	5.97
44	2291541	6.49
45	2276669	7.07
46	2260573	7.66
47	2243257	8.28
48	2224683	8.94
49	2204794	9.66
50	2183496	10.45
51	2160678	11.32
52	2136219	12.30
53	2109944	13.40
54	2081671	14.63
55	2051216	15.90
56	2018602	17.24
57	1983801	18.59
58	1946922	19.97
59	1908042	21.40
60	1867210	22.97
61	1824320	24.79
62	1779095	26.90
63	1731237	29.41
64	1680321	32.19
65	1626231	35.22
66	1568955	38.30
67	1508864	41.48
68	1446276	44.56
69	1381830	47.92
70	1315613	51.48
71	1247885	55.71
72	1178365	60.65
73	1106897	66.38
74	1033421	72.83
75	958157	79.94
76	881562	87.39
77	804522	95.03
78	728068	102.74
79	653266	110.84
80	580858	119.65
81	511358	129.53
82	445122	140.71
83	382489	153.39
84	323819	167.82
85	269476	182.39
86	220326	198.42
87	176609	213.92
88	138829	231.52
89	106687	248.43
90	80183	267.53
91	58732	287.83
92	41827	310.19
93	28853	335.99
94	19159	368.95
95	12090	416.96
96	7049	491.31
97	3586	619.59
98	1364	853.37
99	200	1000.00

Age nearest birthday CSO: Sum qx= 4385.48 Sum 1x= 8045842
* Adjusted; see text CET: Sum qx= 8155.96 Sum 1x= 133888931

1980 CSO–SE SMOKER TABLE &
1980 CET–SE SMOKER TABLE #
Pivotal Age is 45 *** Ratio of Male 1_x to Total is 40%
1980 CSO–SE SMOKER TABLE 11

Age	1_x	$1000q_x$
15	125734	1.22
16	125581	1.35
17	125411	1.45
18	125229	1.52
19	125039	1.59
20	124840	1.63
21	124637	1.65
22	124431	1.65
23	124226	1.65
24	124021	1.65
25	123816	1.64
26	123613	1.64
27	123410	1.66
28	123205	1.67

Age	1_x	$1000q_x$
29	122999	1.71
30	122789	1.77
31	122572	1.84
32	122346	1.91
33	122112	1.99
34	121869	2.11
35	121612	2.22
36	121342	2.38
37	121053	2.59
38	120739	2.82
39	120399	3.08
40	120028	3.38
41	119622	3.73
42	119176	4.09
43	118689	4.46
44	118160	4.85
45	117587	5.28
46	116966	5.70
47	116299	6.16
48	115583	6.64
49	114816	7.16
50	113994	7.74
51	113112	8.36
52	112166	9.07
53	111149	9.87
54	110052	10.74
55	108870	11.65
56	107602	12.61
57	106245	13.57
58	104803	14.52
59	103281	15.51
60	101679	16.61
61	99990	17.89
62	98201	19.38
63	96298	21.20
64	94256	23.20
65	92069	25.40
66	89730	27.62
67	87252	29.91
68	84642	32.12
69	81923	34.50
70	79097	37.05
71	76166	40.10
72	73112	43.72
73	69916	47.97
74	66562	52.76
75	63050	58.07
76	59389	63.65
77	55609	69.39
78	51750	75.26
79	47855	81.40
80	43960	88.17
81	40084	95.75
82	36246	104.35
83	32464	114.13
84	28759	125.35
85	25154	136.67
86	21716	149.23
87	18475	161.37
88	15494	175.15
89	12780	188.35
90	10373	203.38
91	8263	219.41
92	6450	236.87
93	4922	257.15
94	2656	*282.58
95	2623	*319.76
96	1784	*377.41
97	1111	*476.21
98	582	*656.10
99	200	1000.00

1980 CET–SE SMOKER TABLE 12

Age	1_x	$1000q_x$
15	2133421	1.97
16	2129228	2.10
17	2124757	2.20
18	2120083	2.27
19	1225270	2.34
20	2110320	2.38
21	2105297	2.40
22	2100244	2.40
23	2095203	2.40
24	2090175	2.40
25	2085159	2.39
26	2080175	2.39
27	2075203	2.41
28	2070202	2.42
29	2065192	2.46
30	2060112	2.52
31	2054921	2.59
32	2049599	2.66
33	2044147	2.74
34	2038546	2.86
35	2032716	2.97
36	2026679	3.13
37	2020335	3.37
38	2013526	3.67
39	2006136	4.00
40	1998111	4.39
41	1989339	4.85
42	1979691	5.32
43	1969159	5.80
44	1957738	6.31
45	1945385	6.86
46	1932040	7.41
47	1917724	8.01
48	1902363	8.63
49	1885946	9.31
50	1868388	10.06
51	1849592	10.87
52	1829487	11.79
53	1807917	12.83
54	1784721	13.96
55	1759806	15.15
56	1733145	16.39
57	1704739	17.64
58	1674667	18.88
59	1643049	20.16
60	1609925	21.59
61	1575167	23.26
62	1538529	25.19
63	1499773	27.56
64	1458439	30.16
65	1414452	33.02
66	1367747	35.91
67	1318631	38.88
68	1267363	41.76
69	1214438	44.85
70	1159970	48.17

Age	1_x	$1000q_x$
71	1104094	52.13
72	1046538	56.84
73	987053	62.36
74	925500	68.59
75	862020	75.49
76	796946	82.75
77	730999	90.21
78	665056	97.84
79	599987	105.82
80	536496	114.62
81	475003	124.48
82	415875	135.66
83	359457	148.37
84	306124	162.96
85	256238	177.67
86	210712	194.00
87	169834	209.78
88	134206	227.70
89	103647	244.86
90	78268	264.39
91	57575	285.23
92	41153	307.93
93	28481	334.30
94	18960	367.35
95	11995	415.69
96	7009	490.63
97	3570	619.07
98	1360	852.93
99	200	1000.00

Age nearest birthday CSO: Sum qx= 4284.01 Sum 1x= 7234867
* Adjusted; see text CET: Sum qx= 8020.06 Sum 1x= 115338453

1980 CSO–SF SMOKER TABLE &
1980 CET–SF SMOKER TABLE #
Pivotal Age is 45 *** Ratio of Male 1_x to Total Is 20%
1980 CSO–SF SMOKER TABLE 13

Age	1_x	$1000q_x$
15	102794	1.08
16	102683	1.17
17	102563	1.25
18	102435	1.31
19	102301	1.36
20	102162	1.39
21	102020	1.42
22	101875	1.43
23	101729	1.44
24	101583	1.46
25	101435	1.47
26	101286	1.49
27	101135	1.52
28	100981	1.54
29	100825	1.60
30	100664	1.66
31	100497	1.72
32	100324	1.80
33	100143	1.87
34	99956	1.98
35	99758	2.08
36	99551	2.23
37	99329	2.44
38	99087	2.65
39	98824	2.90
40	98537	3.19
41	98223	3.53
42	97876	3.86
43	97498	4.21
44	97088	4.56
45	96645	4.94
46	96168	5.33
47	95655	5.74
48	95106	6.16
49	94520	6.62
50	93894	7.14
51	93224	7.68
52	92508	8.29
53	91741	9.00
54	90915	9.74
55	90029	10.52
56	89082	11.33
57	88073	12.11
58	87006	12.87
59	85886	13.66
60	84713	14.53
61	83482	15.59
62	82181	16.84
63	80797	18.43
64	79308	20.20
65	77706	22.15
66	75985	24.10
67	74154	26.12
68	72217	28.01
69	70194	30.09
70	68082	32.29
71	65884	35.04
72	63575	38.36
73	61136	42.33
74	58548	46.89
75	55803	51.94
76	52905	57.33
77	49872	62.93
78	46734	68.70
79	43523	74.83
80	40266	81.61
81	36980	89.22
82	33681	97.92
83	30383	107.82
84	27107	119.31
85	23873	130.86
86	20749	143.85
87	17764	156.39
88	14986	170.57
89	12430	184.17
90	10141	199.71
91	8116	216.27
92	6361	234.41
93	4870	255.00
94	3628	*280.66
95	2610	*318.37
96	1779	*376.21
97	1110	*475.72
98	582	*656.09
99	200	1000.00

1980 CET–SF SMOKER TABLE 14

Age	1_x	$1000q_x$
15	1629026	1.83
16	1626045	1.92
17	1622923	2.00

Age	1_x	$1000q_x$
18	1619677	2.06
19	1616340	2.11
20	1612930	2.14
21	1609478	2.17
22	1605985	2.18
23	1602484	2.19
24	1598975	2.21
25	1595441	2.22
26	1591899	2.24
27	1588333	2.27
28	1584727	2.29
29	1581098	2.35
30	1577382	2.41
31	1573581	2.47
32	1569694	2.55
33	1565691	2.62
34	1561589	2.73
35	1557326	2.83
36	1552919	2.98
37	1548291	3.19
38	1543352	3.45
39	1538027	3.77
40	1532229	4.15
41	1525870	4.59
42	1518866	5.02
43	1511241	5.47
44	1502975	5.93
45	1494062	6.42
46	1484470	6.93
47	1474183	7.46
48	1463186	8.01
49	1451466	8.61
50	1438969	9.28
51	1425615	9.98
52	1411387	10.78
53	1396172	11.70
54	1379837	12.66
55	1362368	13.68
56	1343731	14.73
57	1323938	15.74
58	1303099	16.73
59	1281298	17.76
60	1258542	18.89
61	1234768	20.27
62	1209739	21.89
63	1183258	23.96
64	1154907	26.26
65	1124579	28.80
66	1092191	31.33
67	1057973	33.96
68	1022044	36.41
69	984831	39.12
70	946304	41.98
71	906578	45.55
72	865283	49.87
73	822131	55.03
74	776889	60.96
75	729530	67.52
76	680272	74.53
77	629571	81.81
78	578066	89.31
79	526439	97.28
80	475227	106.09
81	424810	115.99
82	375536	127.30
83	327730	140.17
84	281792	155.10
85	238086	170.12
86	197583	187.02
87	160633	203.31
88	127975	221.74
89	99598	239.42
90	75752	259.62
91	56085	281.15
92	40317	304.73
93	28031	331.50
94	18739	364.86
95	11902	413.88
96	6976	489.07
97	3564	618.44
98	1360	852.92
99	200	1000.00

Age nearest birthday CSO: Sum qx= 4106.55 Sum 1x= 6040029
* Adjusted; see text CET: Sum qx= 7783.96 Sum 1x= 90033966

1980 CSO–NB NON–SMOKER TABLE &
1980 CET–NB NON–SMOKER TABLE #
Pivotal Age Is 45 *** Ratio of Male 1_x to Total Is 80%
1980 CSO–NB NON–SMOKER TABLE 15

Age	1_x	$1000q_x$
15	116700	1.20
16	116560	1.32
17	116406	1.42
18	116241	1.47
19	116070	1.52
20	115894	1.55
21	115714	1.55
22	115535	1.52
23	115359	1.50
24	115186	1.47
25	115017	1.44
26	114851	1.41
27	114689	1.40
28	114528	1.38
29	114370	1.40
30	114210	1.40
31	114050	1.43
32	113887	1.46
33	113721	1.50
34	113550	1.58
35	113371	1.64
36	113185	1.73
37	112989	1.83
38	112782	1.96
39	112561	2.10
40	112325	2.25
41	112072	2.43
42	111800	2.60
43	111509	2.81
44	111196	3.01
45	110861	3.26
46	110500	3.51
47	110112	3.78
48	109696	4.09
49	109247	4.41
50	108765	4.76
51	108247	5.18
52	107686	5.65
53	107078	6.19
54	106415	6.81

Age	1_x	$1000q_x$
55	105690	7.48
56	104899	8.21
57	104038	9.00
58	103102	9.84
59	102087	10.75
60	100990	11.80
61	99798	12.96
62	98505	14.30
63	97096	15.86
64	95556	17.62
65	93872	19.55
66	92037	21.64
67	90045	23.87
68	87896	26.24
69	85590	28.82
70	83123	31.74
71	80485	35.51
72	77627	38.89
73	74608	43.37
74	71372	48.39
75	67918	53.84
76	64261	59.65
77	60428	65.77
78	56454	72.13
79	52382	78.92
80	48248	86.40
81	440079	94.77
82	39902	104.26
83	35742	115.02
84	31631	126.80
85	27620	139.45
86	23768	152.61
87	20141	166.38
88	16790	180.45
89	13760	195.03
90	11076	210.29
91	8747	*226.51
92	6766	*244.13
93	5114	*264.04
94	3764	*289.36
95	2675	*324.89
96	1806	*380.97
97	1118	*477.69
98	584	*657.38
99	200	1000.00

1980 CET–NB NON–SMOKER TABLE 16

Age	1_x	$1000q_x$
15	1977580	1.95
16	1973724	2.07
17	1969638	2.17
18	1965364	2.22
19	1961001	2.27
20	1956550	2.30
21	1952050	2.30
22	1947560	2.27
23	1943139	2.25
24	1938767	2.22
25	1934463	2.19
26	1930227	2.16
27	1926058	2.15
28	1921917	2.13
29	1917823	2.15
30	1913700	2.15
31	1909586	2.18
32	1905423	2.21
33	1901212	2.25
34	1896934	2.33
35	1892514	2.39
36	1887991	2.48
37	1883309	2.58
38	1878450	2.71
39	1873359	2.85
40	1868020	3.00
41	1862416	3.18
42	1856494	3.38
43	1850219	3.65
44	1843466	3.91
45	1836258	4.24
46	1828472	4.56
47	1820134	4.91
48	1811197	5.32
49	1801561	5.73
50	1791238	6.19
51	1780150	6.73
52	1768170	7.35
53	1755174	8.05
54	1741045	8.85
55	1725637	9.72
56	1708864	10.67
57	1690630	11.70
58	1670850	12.79
59	1649480	13.98
60	1626420	15.34
61	1601471	16.85
62	1574486	18.59
63	1545216	20.62
64	1513354	22.91
65	1478683	25.42
66	1441095	28.13
67	1400557	31.03
68	1357098	34.11
69	1310807	37.47
70	1261691	41.26
71	1209634	46.16
72	1153797	50.56
73	1095461	56.38
74	1033699	62.91
75	968669	69.99
76	900872	77.55
77	831009	85.50
78	759958	93.77
79	688697	102.60
80	618037	112.32
81	548619	123.20
82	481029	135.54
83	415830	149.53
84	353651	164.84
85	295355	181.29
86	241810	198.39
87	193837	216.29
88	151912	234.59
89	116275	253.54
90	86795	273.38
91	63067	294.46
92	44496	317.37
93	30374	343.25
94	19948	376.17
95	12444	422.36
96	7188	495.26

Age	1_x	$1000q_x$
97	3628	621.00
98	1375	854.59
99	200	1000.00

Age nearest birthday CSO: Sum qx= 3436.53 Sum 1x= 7008325
* Adjusted; see text CET: Sum qx= 7899.36 Sum 1x= 112256358

1980 CSO–NC NON–SMOKER TABLE &
1980 CET–NC NON–SMOKER TABLE #
Pivotal Age Is 45 *** Ratio of Male 1_x to Total Is 60%
1980 CSO–NC NON–SMOKER TABLE 17

Age	1_x	$1000q_x$
15	95229	1.11
16	95123	1.22
17	95007	1.29
18	94884	1.34
19	94757	1.39
20	94625	1.41
21	94492	1.42
22	94358	1.40
23	94226	1.39
24	94095	1.37
25	93966	1.35
26	93839	1.33
27	93714	1.33
28	93589	1.33
29	93465	1.35
30	93339	1.36
31	93212	1.39
32	93082	1.42
33	92950	1.47
34	92813	1.53
35	92671	1.60
36	92523	1.68
37	92368	1.80
38	92202	1.91
39	92026	2.06
40	91836	2.21
41	91633	2.38
42	91415	2.57
43	91180	2.76
44	90928	2.96
45	90659	3.19
46	90370	3.43
47	90060	3.69
48	89728	3.98
49	89371	4.28
50	88988	4.62
51	88577	5.00
52	88134	5.46
53	87653	5.96
54	87131	6.52
55	86563	7.14
56	85945	7.80
57	85275	8.51
58	84549	9.24
59	83768	10.05
60	82926	10.97
61	82016	12.01
62	81031	13.21
63	79961	14.62
64	78792	16.24
65	77512	18.01
66	76116	19.91
67	74601	21.94
68	72964	24.05
69	71209	26.35
70	69333	28.95
71	67326	32.26
72	65154	35.42
73	62846	39.52
74	60362	44.17
75	57696	49.24
76	54855	54.70
77	51854	60.43
78	48720	66.46
79	45482	72.92
80	42165	80.06
81	38789	88.10
82	35372	97.27
83	31931	107.73
84	28491	119.23
85	25094	131.61
86	21791	144.68
87	18638	158.40
88	15686	172.60
89	12979	187.46
90	10546	*203.08
91	8404	*219.76
92	6557	*238.20
93	4995	*259.26
94	3700	*285.17
95	2645	*322.03
96	1793	*378.56
97	1114	*476.70
98	583	*657.10
99	200	1000.00

1980 CET–NC NON–SMOKER TABLE 18

Age	1_x	$1000q_x$
15	1495453	1.86
16	1492671	1.97
17	1489730	2.04
18	1486691	2.09
19	1483584	2.14
20	1480409	2.16
21	1477211	2.17
22	1474005	2.15
23	1470836	2.14
24	1467688	2.12
25	1464577	2.10
26	1461501	2.08
27	1458461	2.08
28	1455427	2.08
29	1452400	2.10
30	1449350	2.11
31	1446292	2.14
32	1443197	2.17
33	1440065	2.22
34	1436868	2.28
35	1433592	2.35
36	1430223	2.43
37	1426748	2.55
38	1423110	2.66
39	1419325	2.81
40	1415337	2.96
41	1411148	3.13
42	1406731	3.34
43	1402033	3.59

Age	1_x	$1000q_x$
44	1397000	3.85
45	1391622	4.15
46	1385847	4.46
47	1379666	4.80
48	1373044	5.17
49	1365945	5.56
50	1358350	6.01
51	1350186	6.50
52	1341410	7.10
53	1331886	7.75
54	1321564	8.48
55	1310357	9.28
56	1298197	10.14
57	1285033	11.06
58	1270821	12.01
59	1255558	13.07
60	1239148	14.26
61	1221478	15.61
62	1202411	17.17
63	1181766	19.01
64	1159301	21.11
65	1134828	23.41
66	1108262	25.88
67	1079580	28.52
68	1048790	31.27
69	1015994	34.26
70	981186	37.64
71	944254	41.94
72	904652	46.05
73	862993	51.38
74	818652	57.42
75	771645	64.01
76	722252	71.11
77	670893	78.56
78	618188	86.40
79	564777	94.80
80	511236	104.08
81	458027	114.53
82	405569	126.45
83	354285	140.05
84	304667	155.00
85	257444	171.09
86	213398	188.08
87	173262	205.92
88	137584	224.38
89	106713	243.70
90	80707	264.00
91	59400	285.69
92	42430	309.66
93	29291	337.04
94	19419	370.72
95	12220	418.64
96	7104	492.13
97	3608	619.71
98	1372	854.23
99	200	1000.00

Age nearest birthday CSO: Sum qx= 3086.52 Sum 1x= 5788547
* Adjusted; see text CET: Sum qx= 7672.32 Sum 1x= 85940135

1980 CSO–ND NON–SMOKER TABLE &
1980 CET–ND NON–SMOKER TABLE #
Pivotal Age Is 45 *** Ratio of Male 1_x to Total Is 50%
1980 CSO–ND NON–SMOKER TABLE 19

Age	1_x	$1000q_x$
15	87164	1.07
16	87071	1.16
17	86970	1.23
18	86863	1.27
19	86753	1.32
20	86638	1.35
21	86521	1.34
22	86405	1.34
23	86289	1.33
24	86174	1.33
25	86059	1.30
26	85947	1.30
27	85835	1.29
28	85724	1.31
29	85612	1.33
30	85498	1.34
31	85383	1.37
32	85266	1.40
33	85147	1.45
34	85024	1.51
35	84896	1.58
36	84762	1.67
37	84620	1.77
38	84470	1.90
39	84310	2.03
40	84139	2.19
41	83955	2.36
42	83757	2.55
43	83543	2.73
44	83315	2.93
45	83071	3.16
46	82808	3.39
47	82527	3.65
48	82226	3.92
49	81904	4.22
50	81558	4.55
51	81187	4.92
52	80788	5.36
53	80355	5.85
54	79885	6.38
55	79375	6.97
56	78822	7.60
57	78223	8.26
58	77577	8.95
59	76883	9.70
60	76137	10.55
61	75334	11.53
62	74465	12.66
63	73522	14.01
64	72492	15.56
65	71364	17.24
66	70134	19.07
67	68797	20.98
68	67354	22.99
69	65806	25.15
70	64151	27.60
71	62380	30.69
72	60466	33.75
73	58425	37.67
74	56224	42.16
75	53854	47.06
76	51320	52.38
77	48632	57.96
78	45813	63.84
79	42888	70.16
80	39879	77.18
81	36801	85.11

Age	1_x	$1000q_x$
82	33669	94.17
83	30498	104.54
84	27310	115.93
85	24144	128.27
86	21047	141.31
87	18073	155.09
88	15270	169.35
89	12684	184.40
90	10345	*200.23
91	8274	*217.23
92	6477	*235.91
93	4949	*257.43
94	3675	*283.81
95	2632	*320.74
96	1788	*377.93
97	1112	*476.61
98	582	*656.44
99	200	1000.00

1980 CET–ND NON–SMOKER TABLE 20

Age	1_x	$1000q_x$
15	1321831	1.82
16	1319425	1.91
17	1316905	1.98
18	1314298	2.02
19	1311643	2.07
20	1308928	2.10
21	1306179	2.09
22	1303449	2.09
23	1300725	2.08
24	1298019	2.08
25	1295319	2.05
26	1292664	2.05
27	1290014	2.04
28	1287382	2.06
29	1284730	2.08
30	1282058	2.09
31	1279378	2.12
32	1276666	2.15
33	1273921	2.20
34	1271118	2.26
35	1268245	2.33
36	1265290	2.42
37	1262228	2.52
38	1259047	2.65
39	1255711	2.78
40	1252220	2.94
41	1248538	3.11
42	1244655	3.32
43	1240523	3.55
44	1236119	3.81
45	1231409	4.11
46	1226348	4.41
47	1220940	4.75
48	1215141	5.10
49	1208944	5.49
50	1202307	5.92
51	1195189	6.40
52	1187540	6.97
53	1179263	7.61
54	1170289	8.29
55	1160587	9.06
56	1150072	9.88
57	1138709	10.74
58	1126479	11.64
59	1113367	12.61
60	1099327	13.72
61	1084244	14.99
62	1067991	16.46
63	1050412	18.21
64	1031284	20.23
65	1010421	22.41
66	987777	24.79
67	963290	27.27
68	937021	29.89
69	909013	32.70
70	879288	35.88
71	847739	39.90
72	813914	43.88
73	778199	48.97
74	740091	54.81
75	699527	61.18
76	656730	68.09
77	612013	75.35
78	565898	82.99
79	518934	91.21
80	471602	100.33
81	424286	110.64
82	377343	122.42
83	331149	135.90
84	286146	150.71
85	243021	166.75
86	202497	183.70
87	165298	201.62
88	131971	220.16
89	102916	239.72
90	78245	260.30
91	57878	282.40
92	41533	306.68
93	28796	334.66
94	19159	368.95
95	12090	416.96
96	7049	491.31
97	3586	619.59
98	1364	853.37
99	200	1000.00

Age nearest birthday CSO: Sum qx= 3023.29 Sum 1x= 5330266
* Adjusted; see text CET: Sum qx= 7572.85 Sum 1x= 76433054

1980 CSO–NE NON–SMOKER TABLE &
1980 CET–NE NON–SMOKER TABLE #
Pivotal Age Is 45 *** Ratio of Male 1_x to Total is 40%
1980 CSO–NE NON–SMOKER TABLE 21

Age	1_x	$1000q_x$
15	80445	1.03
16	80362	1.10
17	80274	1.17
18	80180	1.21
19	80083	1.25
20	79983	1.29
21	79880	1.28
22	79778	1.28
23	79676	1.28
24	79574	1.28
25	79472	1.26
26	79372	1.26
27	79272	1.27
28	79171	1.28

Age	1_x	$1000q_x$
29	79070	1.30
30	78967	1.31
31	78864	1.36
32	78757	1.39
33	78648	1.42
34	78536	1.49
35	78419	1.56
36	78297	1.65
37	78168	1.76
38	78030	1.87
39	77884	2.02
40	77727	2.16
41	77559	2.34
42	77378	2.53
43	77182	2.72
44	76972	2.91
45	76748	3.13
46	76508	3.35
47	76252	3.59
48	75978	3.87
49	75684	4.15
50	75370	4.48
51	75032	4.84
52	74669	5.25
53	74277	5.73
54	73851	6.23
55	73391	6.81
56	72891	7.39
57	72352	8.02
58	71772	8.65
59	71151	9.35
60	70486	10.14
61	69771	11.04
62	69001	12.12
63	68165	13.40
64	67252	14.89
65	66251	16.49
66	65159	18.23
67	63971	20.04
68	62689	21.93
69	61314	23.96
70	59845	26.28
71	58272	29.16
72	56573	32.11
73	54756	35.90
74	52790	40.21
75	50667	44.98
76	48388	50.15
77	45961	55.59
78	43406	61.36
79	40743	67.55
80	37991	74.48
81	35161	82.32
82	32267	91.29
83	29321	101.59
84	26342	112.91
85	23368	125.24
86	20441	138.25
87	17615	152.08
88	14936	166.50
89	12449	181.73
90	10187	*197.78
91	8172	*215.12
92	6414	*234.03
93	4913	*255.85
94	3656	*282.58
95	2623	*319.76
96	1784	*377.41
97	1111	*476.21
98	582	*656.10
99	200	1000.00

1980 CET–NE NON–SMOKER TABLE 22

Age	1_x	$1000q_x$
15	1182241	1.78
16	1180137	1.85
17	1177954	1.92
18	1175692	1.96
19	1173388	2.00
20	1171041	2.04
21	1168652	2.03
22	1166280	2.03
23	1163912	2.03
24	1161549	2.03
25	1159191	2.01
26	1156861	2.01
27	1154536	2.02
28	1152204	2.03
29	1149865	2.05
30	1147508	2.06
31	1145144	2.11
32	1142728	2.14
33	1140283	2.17
34	1137809	2.24
35	1135260	2.31
36	1132638	2.40
37	1129920	2.51
38	1127084	2.62
39	1124131	2.77
40	1121017	2.91
41	1117755	3.09
42	1114301	3.29
43	1110635	3.54
44	1106703	3.78
45	1102520	4.07
46	1098033	4.36
47	1093246	4.67
48	1088141	5.03
49	1082668	5.40
50	1076822	5.82
51	1070555	6.29
52	1063821	6.83
53	1056555	7.45
54	1048684	8.10
55	1040190	8.85
56	1030984	9.61
57	1021076	10.43
58	1010426	11.25
59	999059	12.16
60	968910	13.18
61	973903	14.35
62	959927	15.76
63	944799	17.42
64	928341	19.36
65	910368	21.44
66	890850	23.70
67	869737	26.05
68	847080	28.51
69	822930	31.15
70	797296	34.16

Age	1_x	$1000q_x$
71	770060	37.91
72	740867	41.74
73	709943	46.67
74	676810	52.27
75	641433	58.47
76	603928	65.20
77	564552	72.27
78	523752	79.77
79	481972	87.72
80	439645	96.82
81	397079	107.02
82	354584	118.68
83	312502	132.07
84	271230	146.78
85	231419	162.81
86	193742	179.73
87	158921	197.70
88	127502	216.45
89	99904	236.25
90	76302	257.11
91	56684	379.66
92	40832	304.24
93	28409	332.61
94	18960	367.35
95	11995	415.69
96	7009	490.63
97	3570	619.70
98	1360	852.93
99	200	1000.00

Age nearest birthday CSO: Sum qx= 2963.79 Sum 1x= 4948899
* Adjusted; see text CET: Sum qx= 7480.85 Sum 1x= 68786506

1980 CSO–NF NON–SMOKER TABLE &
1980 CET–NF NON–SMOKER TABLE #
Pivotal Age Is 45 *** Ratio of Male 1_x to Total is 20%
1980 CSO–NF NON–SMOKER TABLE 23

Age	1_x	$1000q_x$
15	69713	0.94
16	69647	0.99
17	69578	1.04
18	69506	1.07
19	69432	1.12
20	69354	1.15
21	69274	1.14
22	69195	1.16
23	69115	1.16
24	69035	1.18
25	68954	1.17
26	68873	1.19
27	68791	1.20
28	68708	1.23
29	68623	1.25
30	68537	1.28
31	68449	1.32
32	68359	1.35
33	68267	1.38
34	68173	1.45
35	68074	1.51
36	67971	1.61
37	67862	1.71
38	67746	1.84
39	67621	1.97
40	67488	2.12
41	67345	2.30
42	67190	2.49
43	67023	2.67
44	66844	2.85
45	66653	3.06
46	66449	3.27
47	66232	3.50
48	66000	3.76
49	65752	4.02
50	65488	4.33
51	65204	4.67
52	64899	5.05
53	64571	5.49
54	64217	5.96
55	63834	6.46
56	63422	6.99
57	62979	7.54
58	62504	8.06
59	62000	8.65
60	61464	9.32
61	60891	10.11
62	60275	11.04
63	59610	12.20
64	58883	13.55
65	58085	15.01
66	57213	16.58
67	56264	18.21
68	55239	19.86
69	54142	21.65
70	52970	23.69
71	51715	26.19
72	50361	28.98
73	48902	32.47
74	47314	36.50
75	45587	41.02
76	43717	45.94
77	41709	51.16
78	39575	56.73
79	37330	62.78
80	34986	69.53
81	32553	77.24
82	30039	86.13
83	27452	96.33
84	24808	107.59
85	22139	119.91
86	19484	132.99
87	16893	146.95
88	14411	161.59
89	12082	177.21
90	9941	193.74
91	8015	211.49
92	6320	*231.05
93	4860	*253.44
94	3628	*280.66
95	2610	*318.37
96	1779	*376.21
97	1110	*475.72
98	582	*656.09
99	200	1000.00

1980 CET–NF NON–SMOKER TABLE 24

Age	1_x	$1000q_x$
15	974349	1.69
16	972702	1.74
17	971009	1.79

Age	1_x	$1000q_x$
18	969271	1.82
19	967507	1.87
20	965698	1.90
21	963863	1.89
22	962041	1.91
23	960204	1.91
24	958370	1.93
25	956520	1.92
26	254683	1.94
27	952831	1.95
28	950973	1.98
29	949090	2.00
30	947192	2.03
31	945269	2.07
32	943312	2.10
33	941331	2.13
34	939326	2.20
35	937259	2.26
36	935141	2.36
37	932934	2.46
38	930639	2.59
39	928229	2.72
40	925704	2.87
41	923047	3.05
42	920232	3.24
43	917250	3.47
44	914067	3.71
45	910676	3.98
46	907052	4.25
47	903197	4.55
48	899087	4.89
49	894690	5.23
50	890011	5.63
51	885000	6.07
52	879628	6.57
53	873849	7.14
54	867610	7.75
55	860886	8.40
56	853655	9.09
57	845895	9.80
58	837605	10.48
59	828827	11.25
60	819503	12.12
61	809571	13.14
62	798933	14.35
63	787468	15.86
64	774979	17.62
65	761324	19.51
66	746471	21.55
67	730385	23.67
68	713097	25.82
69	694685	28.15
70	675130	30.80
71	654336	34.05
72	632056	37.67
73	608246	42.21
74	582572	47.45
75	554929	53.33
76	525335	59.72
77	493962	66.51
78	461109	73.75
79	427102	81.61
80	392246	90.39
81	356791	100.41
82	320966	111.97
83	285027	125.23
84	249333	139.87
85	214459	155.88
86	181029	172.89
87	149731	191.04
88	121126	210.07
89	95681	230.37
90	73639	251.86
91	55092	274.94
92	39945	300.37
93	27947	329.47
94	18739	364.86
95	11902	413.88
96	6976	489.07
97	3564	618.44
98	1360	852.92
99	200	1000.00

Age nearest birthday CSO: Sum qx= 3259.34 Sum 1x= 4340089
* Adjusted; see text CET: Sum qx= 7315.40 Sum 1x= 57404657

1980 CET–NG Nonsmoker Table 25

Age	Non–Smoker	Smoker
15	1.61	1.71
16	1.65	1.76
17	1.68	1.81
18	1.71	1.86
19	1.74	1.89
20	1.76	1.92
21	1.78	1.94
22	1.79	1.97
23	1.81	2.00
24	1.83	2.03
25	1.85	2.06
26	1.88	2.11
27	1.90	2.15
28	1.93	2.20
29	1.97	2.26
30	2.00	2.33
31	2.04	2.39
32	2.08	2.46
33	2.13	2.55
34	2.19	2.65
35	2.26	2.76
36	2.36	2.93
37	2.48	3.13
38	2.61	3.39
39	2.75	3.72
40	2.92	4.11
41	3.10	4.52
42	3.29	4.94
43	3.52	5.36
44	3.76	5.77
45	4.02	6.21
46	4.29	6.67
47	4.59	7.14
48	4.90	7.64
49	5.25	8.20
50	5.64	8.80
51	6.07	9.44
52	6.57	10.17
53	7.11	10.97
54	7.67	11.79
55	8.27	12.64
56	8.87	13.47
57	9.45	14.25

Age	Non-Smoker	Smoker
58	10.04	15.02
59	10.70	15.83
60	11.48	16.81
61	12.44	18.03
62	13.64	19.60
63	15.11	21.52
64	16.76	23.65
65	18.54	25.90
66	20.38	28.18
67	22.27	80.39
68	24.22	32.63
69	26.39	35.06
70	28.94	37.93
71	32.05	41.57
72	35.85	46.03
73	40.42	51.34
74	45.67	57.38
75	51.53	63.99
76	57.88	71.01
77	64.68	78.31
78	72.03	86.09
79	80.18	94.52
80	89.45	103.97
81	100.11	114.70
82	112.40	126.89
83	126.26	140.97
84	141.53	156.23
85	158.05	172.45
86	175.71	189.48
87	194.47	207.16
88	214.34	225.58
89	235.50	244.73
90	258.09	265.95
91	282.65	288.81
92	310.09	314.16
93	342.36	343.93
94	383.80	383.80
95	443.33	443.33
96	538.04	538.04
97	698.41	698.41
98	967.15	967.15
99	1000.00	1000.00

1980 CET–SG Smoker Table 26

Age	Non-Smoker	Smoker
15	1.61	1.71
16	1.65	1.76
17	1.68	1.81
18	1.71	1.86
19	1.74	1.89
20	1.76	1.92
21	1.78	1.94
22	1.79	1.97
23	1.81	2.00
24	1.83	2.03
25	1.85	2.06
26	1.88	2.11
27	1.90	2.15
28	1.93	2.20
29	1.97	2.26
30	2.00	2.33
31	2.04	2.39
32	2.08	2.46
33	2.13	2.55
34	2.19	2.65
35	2.26	2.76
36	2.36	2.93
37	2.48	3.13
38	2.61	3.39
39	2.75	3.72
40	2.92	4.11
41	3.10	4.52
42	3.29	4.94
43	3.52	5.36
44	3.76	5.77
45	4.02	6.21
46	4.29	6.67
47	4.59	7.14
48	4.90	7.64
49	5.25	8.20
50	5.64	8.80
51	6.07	9.44
52	6.57	10.17
53	7.11	10.97
54	7.67	11.79
55	8.27	12.64
56	8.87	13.47
57	9.45	14.25
58	10.04	15.02
59	10.70	15.83
60	11.48	16.81
61	12.44	18.03
62	13.64	19.60
63	15.11	21.52
64	16.76	23.65
65	18.54	25.90
66	20.38	28.18
67	22.27	80.39
68	24.22	32.63
69	26.39	35.06
70	28.94	37.93
71	32.05	41.57
72	35.85	46.03
73	40.42	51.34
74	45.67	57.38
75	51.53	63.99
76	57.88	71.01
77	64.68	78.31
78	72.03	86.09
79	80.18	94.52
80	89.45	103.97
81	100.11	114.70
82	112.40	126.89
83	126.26	140.97
84	141.53	156.23
85	158.05	172.45
86	175.71	189.48
87	194.47	207.16
88	214.34	225.58
89	235.50	244.73
90	258.09	265.95
91	282.65	288.81
92	310.09	314.16
93	342.36	343.93
94	383.80	383.80
95	443.33	443.33
96	538.04	538.04

Age	Non-Smoker	Smoker
97	698.41	698.41
98	967.15	967.15
99	1000.00	1000.00

1980 CSO–NG Nonsmoker Table 27

Age	Non-Smoker	Smoker
15	0.84	0.94
16	0.88	0.99
17	0.92	1.04
18	0.95	1.09
19	0.98	1.13
20	1.01	1.16
21	1.02	1.18
22	1.04	1.18
23	1.05	1.23
24	1.08	1.27
25	1.09	1.29
26	1.12	1.34
27	1.14	1.38
28	1.17	1.42
29	1.20	1.48
30	1.24	1.55
31	1.27	1.61
32	1.31	1.68
33	1.35	1.75
34	1.42	1.86
35	1.47	1.94
36	1.56	2.09
37	1.67	2.28
38	1.79	2.49
39	1.93	2.73
40	2.08	3.00
41	2.26	3.33
42	2.44	3.64
43	2.62	3.96
44	2.80	4.28
45	2.99	4.61
46	3.19	4.95
47	3.41	5.31
48	3.65	5.68
49	3.90	6.08
50	4.19	6.54
51	4.50	7.00
52	4.85	7.52
53	5.26	8.13
54	5.68	8.75
55	6.13	9.40
56	6.59	10.05
57	7.05	10.67
58	7.49	11.25
59	7.96	11.85
60	8.51	12.51
61	9.16	13.36
62	9.98	14.39
63	11.01	15.78
64	12.23	17.33
65	13.55	19.07
66	14.97	20.79
67	16.41	22.58
68	17.86	24.20
69	19.41	26.02
70	21.20	27.95
71	23.34	30.45
72	25.99	33.55
73	29.22	37.33
74	33.02	41.74
75	37.32	46.64
76	42.04	51.92
77	47.11	57.46
78	52.53	63.23
79	58.45	69.41
80	65.12	76.26
81	72.76	84.00
82	81.59	92.84
83	91.76	102.87
84	103.03	114.65
85	115.38	126.42
86	128.58	139.79
87	142.71	152.67
88	157.61	167.23
89	173.51	181.07
90	190.39	197.01
91	208.58	214.00
92	228.60	232.54
93	251.40	253.55
94	279.31	279.31
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

1980 CSO–SG Smoker Table 28

Age	Non-Smoker	Smoker
15	0.84	0.94
16	0.88	0.99
17	0.92	1.04
18	0.95	1.09
19	0.98	1.13
20	1.01	1.16
21	1.02	1.18
22	1.04	1.18
23	1.05	1.23
24	1.08	1.27
25	1.09	1.29
26	1.12	1.34
27	1.14	1.38
28	1.17	1.42
29	1.20	1.48
30	1.24	1.55
31	1.27	1.61
32	1.31	1.68
33	1.35	1.75
34	1.42	1.86
35	1.47	1.94
36	1.56	2.09
37	1.67	2.28
38	1.79	2.49
39	1.93	2.73
40	2.08	3.00
41	2.26	3.33
42	2.44	3.64
43	2.62	3.96
44	2.80	4.28
45	2.99	4.61
46	3.19	4.95

Age	Non-Smoker	Smoker
47	3.41	5.31
48	3.65	5.68
49	3.90	6.08
50	4.19	6.54
51	4.50	7.00
52	4.85	7.52
53	5.26	8.13
54	5.68	8.75
55	6.13	9.40
56	6.59	10.05
57	7.05	10.67
58	7.49	11.25
59	7.96	11.85
60	8.51	12.51
61	9.16	13.36
62	9.98	14.39
63	11.01	15.78
64	12.23	17.33
65	13.55	19.07
66	14.97	20.79
67	16.41	22.58
68	17.86	24.20
69	19.41	26.02
70	21.20	27.95
71	23.34	30.45
72	25.99	33.55
73	29.22	37.33
74	33.02	41.74
75	37.32	46.64
76	42.04	51.92
77	47.11	57.46
78	52.53	63.23
79	58.45	69.41
80	65.12	76.26
81	72.76	84.00
82	81.59	92.84
83	91.76	102.87
84	103.03	114.65
85	115.38	126.42
86	128.58	139.79
87	142.71	152.67
88	157.61	167.23
89	173.51	181.07
90	190.39	197.01
91	208.58	214.00
92	228.60	232.54
93	251.40	253.55
94	279.31	279.31
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

Subchapter Historical Note

Subchapter 23 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). 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).

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.

"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.

"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.

"Insured" means any applicant provided coverage by a carrier.

"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 or Section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), or a contract or policy issued under a demonstration project pursuant to amendments to the Federal Social Security Act. 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.

"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.

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 1ii 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.

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. Such 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. Such 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.

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 such 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.

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 such benefits as 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 such conversion opportunities as are 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 succeeding carrier 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."

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 shall be suspended for a period of up to 24 months upon the request of a policyholder or certificateholder who has applied for and been determined entitled to medical assistance under Title XIX of the Social Security Act (that is, Medicaid), during or at the end of which period of suspension, the policy or certificate shall be reinstituted automatically upon notice to the carrier by the policyholder or certificateholder.

1. Benefits and premiums shall not be suspended unless the policyholder or certificateholder provides the carrier notice of entitlement to medical assistance under Title XIX of the Social Security Act within 90 days following the date the policyholder or certificateholder was determined to be so entitled.

2. Upon receipt of a notice of entitlement to medical assistance, the carrier shall return to the policyholder that portion of the premiums already paid which are attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

3. Upon loss of entitlement to medical assistance within the period of suspension, or upon the date following the final day of the period of suspension, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, or effective as of the day following the final day of the period of suspension, if within 90 days following the date of entitlement termination or the final day of the suspension period, the policyholder or certificateholder provides notice to the carrier for reinstitution of the policy or certificate, and pays the premium required by the carrier, which premium shall be for a period of coverage not exceeding six months, inclusive of the 90 day notice period, but exclusive of any period during which the policyholder or certificateholder was entitled to medical assistance pursuant to Medicaid.

4. The coverage under the policy or certificate reinstated:

i. Shall not be subject to any waiting period with respect to treatment of preexisting conditions;

ii. Shall be substantially equivalent to coverage which was in effect prior to the date of suspension of the policy or certificate; and

iii. Shall 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 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.

7. 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.

8. 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.

9. 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.

(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 of Medicare Part B eligible expenses, 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 edu-

cation 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.

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 during the six month period beginning with the first month in which the applicant (who is 65 years of age or older) first 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) 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.

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) 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 (exclusive of any anticipated refund or credit), for the entire period for which rates are computed to provide coverage, 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 which 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. The cell and cell weights, when a model office is used in the calculation of the anticipated loss ratio;

7. A demonstration evidencing that unfair pricing discrimination is not utilized by or incorporated within the policy form's premium table or structure.

i. The demonstration shall show that the recognition or nonrecognition or the homogenization of the elements of any insurance construct will not result in an anticipated loss ratio which would differ by more than 10 percent from the anticipated loss ratio of any element of the construct if the elements of the construct were not recognized or separately recognized, as the case may be.

ii. For the purpose of this paragraph, construct shall mean the risk variables which significantly affect the cost of the coverage. For example, age could be a construct wherein its elements would be age 65, age 66, age 67 and so forth. (Of particular concern are anticipated loss ratios by issue age or issue age groupings.); and

8. A certification signed by an actuary who must be a member of the Society of Actuaries or Casualty Actuarial Society, 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 annually for filing by the Commissioner its rates. Supporting documentation, including ratios of incurred losses to earned premiums by policy duration shall be submitted annually with the rates. Any revision of rates is subject to the requirements of (d) below. The supporting documentation shall demonstrate, using reasonable assumptions, that the anticipated and aggregate loss ratio are at least as great as the originally anticipated loss ratio. Such demonstration shall exclude active life reserves.

(d) Carriers shall submit for filing by the Commissioner in accordance with N.J.A.C. 11:4–23.12 all rate revisions. No carrier shall implement any rate revision until such rate revision has been filed. Submission of rate revisions for filing shall demonstrate that both 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.

1. 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 such premium adjustments as are necessary to produce an expected loss ratio for a policy or certificate in accordance with the appropriate 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 such 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.

2. 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.

3. 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. All such forms shall result in a clear description of the Medicare supplement benefits provided by the policy.

4. 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 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 Statewide 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.

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. 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 and claims shall refer to premiums and claims for insured residents of this State under a specific policy form. However, if the experience is based on fewer than 1,000 life years of exposure for residents of this State, then the premiums and claims shall be a weighted average of the premiums and claims for this State and national experience, where the weighting factor applied to the State experience is the square root of the ratio of "a" to 1,000 ("a" being the number of the life years of exposure).

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.

11:4–23.12 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.

(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.

11:4–23.13 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.

11:4–23.14 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, such 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, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide for delivery to all applicants an informational brochure, which is intended to improve the buyer's ability to select the most appropriate coverage, and to improve the buyer's understanding of Medicare. Delivery of the informational brochure 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. The full text of the approved guide appears as an Appendix to subchapters 16 and 23 of this chapter, Exhibit A, and is entitled "Bridging the Medicare Gaps: A Guide to Medicare Supplements."

7. To ensure uniformity in the content, form and printing of the guide, each carrier shall comply with the following requirements:

i. Carriers and their printers shall use only the printing negatives authorized by the Department of Insurance. Information concerning the purchase of the negatives is available from the Department of Insurance, Division of Public Affairs;

ii. The guide shall be printed according to the following specifications:

(1) The size of the pages shall be 7 × 10 inches;

(2) The guide shall be printed in two colors, black and PMS 321;

(3) The inside page of the guide shall be printed on 70 pound dull Centura or approved equal;

(4) The cover of the guide is to be printed on 8 pt. Champion Kromekote cover, coated two sides;

(5) The cover shall be die cut on back to form a glued pocket two inches deep; and

(6) The guide is to be saddle stitched (two staples);

iii. A chart entitled "Medicare Deductibles and Copayments for 19__" shall be included in the back pocket of each guide. A sample copy of this chart appears as an Appendix to subchapters 16 and 23 of this chapter, Exhibit B. To ensure uniform design, content and printing of the chart, the Department of Insurance, Division of Enforcement and Consumer Protection, Senior Health Insurance Program, will provide sample copies of the chart to carriers, to the format of which carriers shall adhere exactly.

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 by reason of age shall notify insureds under the policy. Such notice is not required for: Medicare supplement policies; policies of one or more employers or labor organizations, or 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, or members or former members, or combination thereof, of the labor organization; or policies issued pursuant to a contract under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.). Such 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. Such 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 Medicare Supplement Buyer's Guide, available from the company."

(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.

11:4–23.15 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 replace any Medicare supplement or other health policy or certificate in force, or 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 are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

iii. The benefits and premiums under your Medicare supplement policy will be suspended 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 reinstituted if requested within 90 days of losing Medicaid eligibility.

iv. Counseling services may be available in your State to provide advice concerning your purchase of Medicare supplement coverage and concerning Medicaid.

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, including any health care service contract or health maintenance organization contract? If so, with which company?

ii. Do you have any other health insurance coverage that provides benefits which this Medicare supplement policy would duplicate?

(1) If so, with which company?

(2) What kind of coverage?

iii. If the answer to question 1 or 2 is yes, do you intend to replace these medical or health coverages with this policy (certificate)?

iv. Are you covered by Medicaid?

(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 10 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 in 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.

11:4–23.16 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 the Medicare Supplement Acts of this State and the Trade Practices Act, N.J.S.A. 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.

11:4–23.17 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. Establish procedures for determining whether a replacement policy contains benefits clearly and substantially greater than the benefits provided under the replaced policy and thereby institute guidelines as to when first year commissions or replacement commissions are appropriate pursuant to N.J.A.C. 11:4–23.13;

4. 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."

5. 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

6. 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 the Trade Practices Act, 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.

11:4–23.18 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.

11:4–23.19 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.

11:4–23.20 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, CN 325, Trenton, New Jersey 08625–0325, directed to specific bureaus as follows:

1. Health Care Plan Bureau, for submissions from health maintenance organizations and such other similar entities;

2. Service Corporation Bureau, for submissions from health, hospital and medical service corporations; and

3. Statutory Compliance Bureau—Health, for submissions from all other carriers.

(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, CN 325, Trenton, New Jersey 08625–0325, to the attention of Medicare Supplement Multiple Policy Report.

11:4–23.21 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.

11:4–23.22 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.

SUBCHAPTER 24. SMOKER AND NONSMOKER MORTALITY TABLES

Subchapter Historical Note

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

11:4–24.1 Purpose

The purpose of this subchapter is to authorize the use of mortality tables adopted after September 11, 1981 by the National Association of Insurance Commissioners in determining minimum nonforfeiture standards and minimum valuation standards.

11:4–24.2 Definitions

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

"1980 CSO Table" means that mortality table, consisting of separate rates of mortality for male and female lives, prescribed by N.J.S.A. 17B:19–8a(i) and N.J.S.A. 17B:25–19h(viii) and referred to therein as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten Year Mortality Factors.

"1980 CET Table" means that mortality table, consisting of separate rates of mortality for male and female lives, prescribed by N.J.S.A. 17B:25–19h(viii) and referred to therein as the Commissioners 1980 Extended Term Insurance Table.

"1958 CSO Table" means that mortality table prescribed by N.J.S.A. 17B:9–8a(i) and N.J.S.A. 17B:25–19g and referred to therein as the Commissioners 1958 Standard Ordinary Mortality Table.

"1958 CET Table" means that mortality table prescribed by N.J.S.A. 17B:25–19g and referred to therein as the Commissioners 1958 Extended Term Insurance Table.

"Smoker and nonsmoker mortality tables" means the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the 1980 CSO, 1980 CET, 1958 CSO and 1958 CET tables defined above and approved by the National Association of Insurance Commissioners in December 1983.

"Composite mortality tables" means the 1980 CSO, 1980 CET, 1958 CSO and 1958 CET mortality tables defined above, as they were originally published with rates of mortality that do not distinguish between smokers and nonsmokers.

11:4–24.3 Smoker and nonsmoker mortality tables

(a) In determining minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits, and minimum reserve liabilities for any policy of insurance delivered or issued for delivery in this State after the operative date of N.J.S.A. 17B:25–19h(xi) for that policy form and before January 1, 1989, at the option of the insurer and subject to the conditions in (e) below, the following tables may be substituted:

1. The 1958 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table; and

2. The 1958 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

(b) For any category of insurance issued on female lives using 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables in determining minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits, and minimum reserve liabilities, such minimum values may be calculated according to an age not more than six years younger than the actual age of the insured.

(c) Once an election has been made to use a 1980 CSO Mortality Table for a plan of insurance, the substitution in (a) above shall not be available for any subsequent new plan of insurance.

(d) In determining minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits, and minimum reserve liabilities for any policy of insurance delivered or issued for delivery in this State after the operative date of N.J.S.A. 17B:25–19h(xi) for that policy, at the option of the insurer and subject to the conditions in (e) below, the following tables may be substituted.

1. The 1980 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table; and

2. The 1980 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Tables.

(e) For each policy form with separate rates for smoker and nonsmoker, an insurer may:

1. Use composite mortality tables to determine minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits and minimum reserve liabilities;

2. Use smoker and nonsmoker mortality tables to determine the valuation net premiums and minimum reserves, if any, required by N.J.S.A. 17B:19–8e and use composite minimum amounts and minimum periods of nonforfeiture benefits and basic minimum reserve liabilities; or

3. Use smoker and nonsmoker mortality tables to determine minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits and minimum reserve liabilities.

11:4–24.4 Separability

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

SUBCHAPTER 25. (RESERVED)

Subchapter Historical Note

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

SUBCHAPTER 26. ANNUITY MORTALITY TABLES

Subchapter Historical Note

Subchapter 26 was adopted as R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 2908(a).

11:4–26.1 Purpose

The purpose of the new subchapter is to recognize new mortality tables, the 1983 Table "a" and the 1983 GAM Table, for use in determining the minimum standard of valuation for annuity and pure endowment contracts.

11:4–26.2 Definitions

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

"1983 Table 'a' " means that mortality table adopted as a recognized mortality table for annuities in June, 1982 by the National Association of Insurance Commissioners.

"1983 GAM Table" means that mortality table adopted as a recognized mortality table for annuities in December, 1983 by the National Association of Insurance Commissioners.

11:4–26.3 Individual annuity or pure endowment contracts

(a) The 1983 Table "a" is approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual or pure endowment contract issued on or after September 11, 1981.

(b) The 1983 Table "a" shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1987.

11:4–26.4 Group annuity or pure endowment contracts

(a) The 1983 GAM Table and the 1983 Table "a" are approved as group annuity mortality tables for valuation and, at the option of the company either table may be used for purposes of valuation for any annuity or pure endowment purchased on or after September 11, 1981 under a group annuity or pure endowment contract.

(b) The 1983 GAM Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1987 under a group annuity or pure endowment contract.

11:4–26.5 Separability

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

SUBCHAPTER 27. REPORTING A LIQUOR LAW LIABILITY LOSS EXPERIENCE STATISTICS

11:4–27.1 Purpose

The purpose of this subchapter is to implement the statutory intent on N.J.S.A. 17:23–16, 17 and 18.

11:4–27.2 Scope

This subchapter shall apply to all insurers authorized to do business in New Jersey who issue policies covering liquor law liability for insureds in New Jersey.

11:4–27.3 Definitions

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

"Calendar-accident year" means the premiums earned during a 12–month period, and the paid and outstanding losses and claims resulting from accidents that occurred during the same period.

"Earned premium" means the portion of the written premium applicable to the expired or used part of the period for which the premium has been charged.

"Incurred losses outstanding" means the total amount of unpaid losses for claims for which the insurer is liable as of a specific date.

"Incurred losses paid" means all money paid to claimants or policyholders in direct settlement of a loss covered by the policies, including allocated claim expenses.

"Written premiums" means the total amount of premiums for all policies, plus additional premiums from endorsements and audits, but less return premiums from endorsements and cancellations. Reinsurance premiums are not to be considered either for reinsurance ceded or accepted.

11:4–27.4 Schedule and procedures for reporting liquor law liability loss experience statistics

(a) Each insurer authorized to do business in New Jersey, which issues policies covering liquor law liability for insureds in New Jersey, shall provide the Commissioner of Insurance with liquor law liability premium, loss and claim experience data, on an annual basis, for three calendar-accident years, 1984, 1985 and 1986 in accordance with the following schedule; for calendar-accident year 1984, losses valued as of March 31, 1985 shall be due on June 10, 1986; for calendar-accident years 1984 and 1985, losses valued as of March 31, 1986 shall be due on June 10, 1986; for calendar-accident years 1984, 1985 and 1986, losses valued as of March 31, 1987 shall be due on June 10, 1987.

(b) Each insurer authorized to do business in New Jersey, which issues policies covering liquor law liability for insureds in New Jersey, shall segregate, for each calendar-accident year, the data required in (a) above for those insureds which have an alcohol breath analyzer machine on their premises from those insureds which do not.

1. The data required by this subchapter shall be indicated on Forms A and B, appended to this subchapter, and shall be submitted to:

Department of Insurance
Property/Liability
20 West State Street
CN 325
Trenton, New Jersey 08625

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).
In (b)1: Revised address.

11:4–27.5 Penalties

Failure to comply with this subchapter shall result in penalties pursuant to the insurance laws of New Jersey.

APPENDIX A

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
LIQUOR LAW LIABILITY INSURANCE
RISKS WITH ALCOHOL BREATH ANALYZER
MACHINES ON PREMISES

FORM A

Company Name _____

Calendar–Accident Year	Losses Valued as of	Premiums Written	Premiums Earned	Incurred Losses Paid	Incurred Losses Outstanding	Number of Claims †
1984	3/31/85					
1984	3/31/86					
1984	3/31/87					
1985	3/31/86					
1985	3/31/87					
1986	3/31/87					

† NOTE: Cases to be counted as claims shall be only those in connection with which a loss payment has been made or a loss reserve established. A claim partly paid and partly outstanding shall be counted only once. A claim on which more than one payment is made shall be counted only once.

APPENDIX B

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
LIQUOR LAW LIABILITY INSURANCE
RISKS WITHOUT ALCOHOL BREATH ANALYZER
MACHINES ON PREMISES

FORM B

Company Name _____

Calendar–Accident Year	Losses Valued as of	Premiums Written	Premiums Earned	Incurred Losses Paid	Incurred Losses Outstanding	Number of Claims †
1984	3/31/85					
1984	3/31/86					
1984	3/31/87					
1985	3/31/86					
1985	3/31/87					
1986	3/31/87					

† NOTE: Cases to be counted as claims shall be only those in connection with which a loss payment has been made or a loss reserve established. A claim partly paid and partly outstanding shall be counted only once. A claim on which more than one payment is made shall be counted only once.

SUBCHAPTER 28. GROUP COORDINATION OF BENEFITS

Subchapter Historical Note

Subchapter 28 was adopted as R.1988 d.499, effective October 17, 1988. See: 20 N.J.R. 1773(b), 20 N.J.R. 2581(a).

11:4–28.1 Purpose; applicability

(a) The purpose of this subchapter is to:

1. Discourage overinsurance and avoid duplication of benefits by permitting a reduction of benefits when a person is covered by more than one plan providing benefits or services for medical, dental, or other care or treatment;

2. Avoid claims payment delays and misunderstandings that result from the use of inconsistent or incompatible nonduplication provisions; and

3. Establish uniformity in the order in which plans pay their claims, and provide the authority for the orderly transfer of information needed to pay claims promptly.

(b) This subchapter applies to group contracts providing health care benefits which are issued, amended, or renewed by health insurers, health service corporations, hospital service corporations, medical service corporations, dental service corporations, dental plan corporations and all similar organizations.

11:4–28.2 Definitions

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

"Allowable expense" means the necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition.

1. Notwithstanding the above definition, items of expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan which provides benefits only for any such items of expense may limit its definition of allowable expenses to like items of expense.

2. When a plan provides benefits in the form of services, the reasonable monetary value of each service shall be considered as both an allowable expense and a benefit paid.

3. The difference between the cost of a private hospital room and the cost of a semi-private hospital room shall not be considered an allowable expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

4. When COB is restricted in its use to specific coverage in a contract (for example, major medical or dental), the definition of allowable expense shall include only the corresponding expenses or services to which COB applies.

"Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

1. Services (including supplies);

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:

1. The benefits of the plan of the parent whose birthday falls earlier in a year shall be determined before those of the plan of the parent whose birthday falls later in that year.

2. If both parents have the same birthday, the benefits of the plan which covered the parent longer shall be determined before those of the plan which covered the other parent for a shorter period of time.

3. The word "birthday" refers only to month and day in a calendar year and not the year in which the person was born.

4. If the other plan does not follow the rules described in (b)1, 2 and 3 above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent shall determine the order of benefits.

(c) If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child shall be determined according to the provisions of this subsection:

1. The plan of the parent with custody of the child shall have its benefits determined first;

2. The plan of the spouse of the parent with the custody of the child shall have its benefits determined next;

3. The plan of the parent not having custody of the child shall have its benefits determined last.

4. If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and if the plan of that parent is a secondary plan, and further, if the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, then the benefits of that plan shall be determined first. The plan of the other parent shall be considered the secondary plan. This paragraph shall not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the entity that has actual knowledge.

(d) The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) shall be determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this particular provision, and if, as a result, the plans do not agree on the order of benefits, this subsection shall be ignored.

(e) If none of the provisions of (c) and (d) above determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer shall be determined before those of the plan which covered that person for the shorter term.

1. To determine the time a person has been covered under a plan, successive plans of a given group shall be treated as one if the claimant was eligible under the second plan within 24 hours after the first plan ended.

2. The start of a new plan shall not include:

i. A change in the amount or scope of a plan's benefits;

ii. A change in the entity which pays, provides or administers the plan's benefits; and

iii. A change from one plan to another (such as, from a single employer plan to that of a multiple employer plan).

3. The claimant's time covered under a plan shall be measured from the claimant's initial date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the time of the claimant's coverage under the present plan.

11:4–28.7 Procedure to be followed by secondary plan to reduce benefits

(a) A plan determined to be a secondary plan pursuant to N.J.A.C. 11:4–28.6 may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than the total allowable expenses. The amount by which the secondary plan's benefits have been reduced shall be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the secondary plan shall determine its obligation to pay for allowable expenses based on all claims which were submitted up to that time during the claim determination period.

(b) The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision, and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those allowable expenses in a claim determination period. In this case, the benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

(c) When the benefits of This Plan are reduced as described in (a) or (b) above, each benefit shall be reduced in proportion, and the amount paid shall then be charged against any applicable benefit limit of This Plan.

(d) The requirements of (c) above may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

11:4–28.8 Reasonable monetary value of services

A secondary plan which provides benefits in the form of services may recover from the primary plan the reasonable monetary value of providing the services to the extent that benefits for the services are covered by the primary plan. Nothing in this section shall be interpreted to require a plan to pay a covered person money for the value of services provided by a plan which provides benefits in the form of services.

11:4–28.9 Excess and other nonconforming provisions

(a) Where a plan has order of benefits determination rules which are inconsistent with this subchapter and declares that the plan's coverage is "excess" or "always secondary" the following shall apply. Such inconsistencies and declarations can occur because certain plans may not be subject to this subchapter or because some group contracts have not yet conformed to the requirements of this subchapter pursuant to N.J.A.C. 11:4–28.11.

1. A plan with order of benefit determination rules which comply with this subchapter (complying plan) shall coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this subchapter (noncomplying plan) on the following basis:

i. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis;

ii. If the complying plan is the secondary plan, it shall attempt to coordinate in the secondary position with benefits available through the noncomplying plan. The complying plan shall attempt to secure the necessary information from the noncomplying plan. If the noncomplying plan is unwilling to act as primary plan or to supply the necessary information, the complying plan shall assume the primary position and pay its benefits as the primary plan.

11:4–28.10 Substitute terminology in contracts

A term such as "usual and customary", "usual and prevailing", or "reasonable and customary", may be substituted for the term "necessary, reasonable and customary" in a contract. Terms such as "medical care" or "dental care" may be substituted for "health care" in a contract to describe the coverages to which the COB provisions apply.

11:4–28.11 Compliance

(a) Every group contract which provides health care benefits and which is issued on or after January 1, 1989, shall comply with this subchapter.

(b) A group contract which provides health care benefits and which has been issued before January 1, 1989, shall be brought into compliance with this subchapter by the later of:

1. The next anniversary date or renewal date of the group contract following January 1, 1989; or

2. The expiration, following January 1, 1989, of any applicable collectively-bargained contract under which it was written.

11:4–28.12 Severability

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

APPENDIX A

MODEL COB PROVISIONS
COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

(I) APPLICABILITY.

(A) This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

(B) If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

i. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

ii. May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in Section (IV) Effect on the Benefits of This Plan.

(C) If this COB provision applies, but the other plan assumes an always secondary position or refuses to follow the order of benefit determination rules, the benefits of This Plan shall not be reduced.

(II) DEFINITIONS.

(A) "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment;

i. Group insurance or group or group-type coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

ii. Coverage under a governmental plan, or coverage required or provided by law. This does not include a State plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other nongovernmental program.

Each contract or other arrangement for coverage under ii. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

(B) "This Plan" is the part of the group contract that provides benefits for health care expenses.

(C) "Primary Plan/Secondary Plan". The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

(D) "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable monetary value of each service rendered will be considered both an Allowable Expense and a benefit paid.

(E) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

(III) ORDER OF BENEFIT DETERMINATION RULES.

(A) General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

i. The other plan has rules coordinating its benefits with those of This Plan; and

ii. Both those rules and This Plan's rules, in subparagraph (B) below, require that This Plan's benefits be determined before those of the other plan.

(B) Rules. This Plan determines its order of benefits using the first of the following rules which applies:

i. Nondependent/Dependent. The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent.

ii. Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph (B)iii below, when This Plan and another plan cover the same child as a dependent of different persons called "parents":

a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

b. If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in a. immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

iii. Dependent Child/Separated or Divorced Parents. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. First, the plan of the parent with custody of the child;

b. Then, the plan of the spouse of the parent with the custody of the child; and

c. Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and if the plan of that parent is a secondary plan, and further, if the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

iv. Active/Inactive Employee. The benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (iv) is ignored.

v. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter term.

(IV) EFFECT ON THE BENEFITS OF THIS PLAN.

(A) When This Section Applies. This Section (IV) applies when, in accordance with Section (III) Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in (B) immediately below.

(B) Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

i. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

ii. The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. The amount paid is then charged against any applicable benefit limit of This Plan.

(V) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. (Insurer) has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. (Insurer) need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give (Insurer) any facts it needs to pay the claim.

(VI) FACILITY OF PAYMENT.

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, (Insurer) may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. (Insurer) will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable monetary value of the benefits provided in the form of services.

(VII) RIGHT OF RECOVERY.

If the amount of the payments made by (Insurer) is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(A) The persons it has paid or for whom it has paid;

(B) Insurance companies; or

(C) Other organizations.

The "amount of the payments made" includes the reasonable monetary value of any benefits provided in the form of services.

SUBCHAPTER 29. HOMEOWNERS COMPARISON SURVEY

Subchapter Historical Note

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

11:4-29.1 Purpose and scope

(a) This subchapter requires the submission of data by insurers concerning premiums on personal homeowners, tenant and/or condominium coverage to enable the Department to compile an annual Homeowners Insurance Price Comparison Guide for use by the general public.

(b) This subchapter applies to every insurer authorized to provide and sell personal homeowners, tenant and/or condominium coverage insurance in the State of New Jersey.

11:4-29.2 Definitions

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

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

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

"Insurer" means a company writing homeowners, tenants and/or condominium policies in the State of New Jersey.

"Personal homeowners, tenant and/or condominium coverage" means a policy insuring the dwelling structure, contents, personal liability and medical payments in kinds and amounts set forth by the Commissioner.

11:4-29.3 Coverage option survey requirements

(a) Every insurer shall prepare and file with the Commissioner a premium survey concerning premiums charged on personal homeowners, tenant and/or condominium coverage in the following manner:

1. The survey shall reflect the total number of homeowners, tenant and/or condominium policies issued by each insurer as of December 31 of the reporting year.

2. Survey forms reflecting premiums for homeowners, tenants and/or condominium policies as of December 31 of the reporting year shall be filed with the Commissioner on or before January 31 of the following year.

3. Completed coverage option survey forms shall be submitted to:

Director of Consumer Affairs
State of New Jersey
Department of Insurance
20 West State Street
CN–325
Trenton, New Jersey 08625–0325

4. In the preparation and filing of the information required by this subchapter, insurers shall use forms prescribed and provided by the Commissioner. These forms appear in Appendices A, B and C of this subchapter, which are hereby incorporated by reference as part of this subchapter.

APPENDIX A

Company Name: _____

Affiliated with Group (name): _____

Price Comparison Survey

Period Ending: _____

A. Homeowners Coverage: Policy Form HO–3, frame structure built five years ago as of December 31 of the reporting year with a smoke detector, dwelling amount $110,000, personal liability $100,000, medical payments $1,000, $250.00 deductible, five miles or less to a fire station and within 1,000 feet of a hydrant or usable suction point and both dwelling and contents amounts written on a replacement cost basis. Price as of December 31, of the reporting year. All surcharges should be included in premium price.

If Your Policy Differs From Above, Please Explain: _____

_____

List Any Dividends Your Company Offers: _____

_____

Location		Annual Premium
1. Cities		
City of Bayonne	County of Hudson	* _____ *
Camden	Camden	* _____ *
Clifton	Passaic	* _____ *
E. Orange	Essex	* _____ *
Elizabeth	Union	* _____ *
Jersey City	Hudson	* _____ *
Newark	Essex	* _____ *
Passaic	Passaic	* _____ *
Paterson	Passaic	* _____ *
Trenton	Mercer	* _____ *
Woodbridge	Middlesex	* _____ *
2. Other than Cities		
County of Atlantic		* _____ *
Bergen		* _____ *
Burlington		* _____ *
Camden		* _____ *
Cape May		* _____ *
Cumberland		* _____ *
Essex		* _____ *
Gloucester		* _____ *
Hudson		* _____ *
Hunterdon		* _____ *
Mercer		* _____ *
Middlesex		* _____ *
Monmouth		* _____ *
Morris		* _____ *
Ocean		* _____ *
Passaic		* _____ *
Salem		* _____ *
Somerset		* _____ *
Sussex		* _____ *
Union		* _____ *
Warren		* _____ *

As of January 1, 19___, _____ (company name) had _____ New Jersey homeowners policies in force.

As of December 31, 19___, _____ (company name) had _____ New Jersey homeowners policies in force.

_____
Signature of Officer or Senior Manager
Phone Number: _____

APPENDIX B

Company Name: _____

Affiliated with Group (name): _____

Price Comparison Survey

Period Ending: _____

B. Tenant Coverage: Policy Form HO–4, contents amount $15,000, personal liability $100,000, medical payments $1,000, smoke detector, $250.00 deductible and five miles or less to a fire station and within 1,000 feet of a hydrant or useable suction point with contents amount written on a replacement cost basis. Price as of December 31, of the reporting year. All surcharges should be included in premium price.

If Your Policy Differs From Above Please Explain: _____

_____

List Any Dividends Your Company Offers: _____

_____

Location		Annual Premium
1. Cities		
City of	County of	
Bayonne	Hudson	* *
Camden	Camden	* *
Clifton	Passaic	* *
E. Orange	Essex	* *
Elizabeth	Union	* *
Jersey City	Hudson	* *
Newark	Essex	* *
Passaic	Passaic	* *
Paterson	Passaic	* *
Trenton	Mercer	* *
Woodbridge	Middlesex	* *
2. Other than Cities		
County of		
Atlantic		* *
Bergen		* *
Burlington		* *
Camden		* *
Cape May		* *
Cumberland		* *
Essex		* *
Gloucester		* *
Hudson		* *
Hunterdon		* *
Mercer		* *
Middlesex		* *
Monmouth		* *
Morris		* *
Ocean		* *
Passaic		* *
Salem		* *
Somerset		* *
Sussex		* *
Union		* *
Warren		* *

As of January 1, 19___, _____ (company name) had _____ New Jersey tenant policies in force.

As of December 31, 19___, _____ (company name) had _____ New Jersey tenant policies in force.

_____
Signature of Officer or Senior Manager
Phone Number: _____

APPENDIX C

Company Name: _____

Affiliated with Group (name): _____

Price Comparison Survey

Period Ending: _____

C. Condominium Coverage: Policy Form HO–6, owner occupied only, contents amount $15,000, personal liability $100,000, medical payments $1,000, smoke detector, $250.00 deductible and five miles or less to a fire station and within 1,000 feet of a hydrant or useable suction point with contents amount written on a replacement cost basis. Price as of December 31, of the reporting year.

If Your Policy Differs From Above, Please Explain: _____

_____

List Any Dividends Your Company Offers: _____

_____

Location		Annual Premium
1. Cities		
City of	County of	
Bayonne	Hudson	* *
Camden	Camden	* *
Clifton	Passaic	* *
E. Orange	Essex	* *
Elizabeth	Union	* *
Jersey City	Hudson	* *
Newark	Essex	* *
Passaic	Passaic	* *
Paterson	Passaic	* *
Trenton	Mercer	* *
Woodbridge	Middlesex	* *
2. Other than Cities		
County of		
Atlantic		* *
Bergen		* *
Burlington		* *
Camden		* *
Cape May		* *
Cumberland		* *
Essex		* *
Gloucester		* *
Hudson		* *
Hunterdon		* *
Mercer		* *
Middlesex		* *
Monmouth		* *
Morris		* *
Ocean		* *
Passaic		* *
Salem		* *
Somerset		* *
Sussex		* *
Union		* *
Warren		* *

As of January 1, 19___, _____ (company name) had _____ New Jersey condominium policies in force.

As of December 31, 19___, _____ (company name) had _____ New Jersey condominium policies in force.

_____
Signature of Officer or Senior Manager
Phone Number: _____

SUBCHAPTER 30. (RESERVED)

SUBCHAPTER 31. TERM LIFE INSURANCE COMPARISON SURVEY

Subchapter Historical Note

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

11:4–31.1 Purpose and scope

(a) This subchapter requires annual submission of data by insurers to the Department of Insurance, relevant to premium information on annual, renewable, convertible term life insurance policies so that the Department may compile an annual Term Life Insurance Comparison Guide for use by the general public.

(b) This subchapter applies to every insurer authorized to provide and sell life insurance policies in the State of New Jersey.

(c) This subchapter applies to all policies for annual, renewable, convertible term life insurance which were issued on or after January 1, 1988.

11:4–31.2 Definitions

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

"Annual, renewable, convertible term life insurance" means term insurance issued which provides renewal privileges, which has conversion privileges, and which provides premium increases on an attained age basis. This definition does not apply to indeterminate premium contracts, wherein the premium may be changed by the company subject to contractual maximums, nor does it apply to term contracts with re-entry options, wherein the insured may qualify for reduced premiums upon submission of satisfactory evidence of insurability.

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

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

"Insurer" means any legal entity authorized to write life insurance in the State of New Jersey who issues individual term life insurance in this State.

"Standard risk," means a usual and customary underwriting classification assigned to those insureds who do not smoke and who are expected to experience normal rates of mortality.

11:4–31.3 Coverage option survey

(a) Every insurer shall complete and file with the Department a premium survey requesting information on annual, renewable, convertible individual term life insurance policies with a face amount of $100,000 as set forth below:

1. Insurers shall use the forms prescribed and provided by the Commissioner, which appear as Appendices A, B, and C of this subchapter, and are incorporated herein by reference as part of this subchapter.

2. The insurer shall provide the total number of individual annual term life insurance policies containing renewal and conversion privileges issued between January 1 through December 31 of the calendar year for which the survey is being conducted, inclusive of those dates.

i. The requested aggregate information shall include policies which become available for purchase by proposed insureds during the reported survey period.

ii. The requested aggregate information shall include policies which become unavailable to proposed insureds during the reported survey period.

3. The insurer shall provide the premium rates which apply to male and female insureds in age groups of 25, 35, 45 and 50 years, only for policies which are current and available for purchase by proposed insureds as of December 31st of the survey period being reported.

4. The insurer shall provide the annual dividend rate, if any, which applies to male and female insureds in each age group only for policies which are current and available for purchase by proposed insureds as of December 31st of the survey period being reported.

5. The insurer shall provide the projected premium and dividend rates which apply to male and female insureds in each age group for the sixth and eleventh policy year of the individual policy, but only for those policies which are current and available for purchase by proposed insureds as of December 31st of the survey period being reported.

6. Information for each current policy for which premium and/or dividend rates are to be reported for a particular survey period is to be submitted on separate sets of forms (Appendices A, B and C), and identified by its policy plan number.

(b) Survey forms shall be filed with the Department not later than the 31st day of March next following the survey period, which shall be that calendar year immediately preceding that March 31st. Completed coverage option survey forms shall be submitted to:

Director of Consumer Affairs
Department of Insurance
20 West State Street
CN–325
Trenton, New Jersey 08625–0325

11:4–31.4 Survey forms

(a) Insurers shall file all requested aggregate information for annual, renewable, convertible term life policies during the survey period as specified in the upper portion of the form in Appendix A.

(b) Insurers shall file current policy plan information for the first policy year as specified in the lower portion of the form in Appendix A.

(c) Insurers shall file current projected policy plan information for the sixth and eleventh year of the policy, as specified in the forms in Appendices B and C.

APPENDIX A

NJ DEPARTMENT OF INSURANCE TERM LIFE QUESTIONNAIRE

COMPANY _____ .
PERSON FILING FORM (TITLE) _____ .
PHONE _____ .
NUMBER OF INDIVIDUAL ANNUAL RENEWABLE TERM POLICIES IN FORCE IN NJ (AS OF DECEMBER 31, 19__) _____ .
TOTAL INDIVIDUAL ANNUAL RENWABLE TERM PREMIUM WRITTEN 19__ (INCLUDE ONLY NEW BUSINESS, NOT RENEWAL, ON AN ANNUALIZED BASIS) IN NJ? _____ .
DOES COMPANY PAY ANNUAL DIVIDENDS? _____ .
HOW IS THE POLICY SOLD? AGENTS _____ DIRECT MAIL _____ OTHER (EXPLAIN) _____ .
A.M. BEST CO. RATING _____ .
(FOR THE ABOVE DATA, PLEASE PROVIDE COMPANY AGGREGATES FOR THE TERM JAN. 1 TO DEC. 31 OF THE REPORTING YEAR.)

PLEASE PROVIDE PREMIUM RATES FOR A $100,000 FACE AMOUNT, ANNUAL, RENEWABLE, CONVERTIBLE TERM LIFE POLICY FOR THE FIRST POLICY YEAR. RATES SHOULD INCLUDE EXPENSE CHARGES AND REFLECT THE EXACT PREMIUM AS PAID BY A CONSUMER. DO NOT LIST RATES PER $1,000.
POLICY PLAN (FORM) NUMBER _____ .

ISSUE AGE	*UNDER-WRITING	MALE STANDARD PREMIUM	MALE STANDARD DIVIDEND	FEMALE STANDARD PREMIUM	FEMALE STANDARD DIVIDEND
25					
35					
45					
50					

*PLEASE ANSWER BY USING APPROPRIATE LETTER A) MEDICAL EXAM_____ B) QUESTIONNAIRE _____ C) OTHER, EXPLAIN _____ .

(FOR DATA ABOVE AND ON FORMS B & C, PLEASE PROVIDE DATA FOR ONLY THOSE POLICY PLANS STILL IN EFFECT ON DEC. 31 OF THE REPORTING YEAR USE A SEPARATE SET OF FORMS FOR EACH POLICY PLAN.)

(EXHIBIT A)
PLEASE RETURN TO:
DIRECTOR OF CONSUMER AFFAIRS
NEW JERSEY DEPARTMENT OF INSURANCE
20 W. STATE STREET
TRENTON, NJ 08625

APPENDIX B

NJ DEPARTMENT OF INSURANCE TERM LIFE QUESTIONNAIRE

PLEASE PROVIDE PREMIUM RATES FOR A $100,000 FACE AMOUNT, ANNUAL, RENEWABLE, CONVERTIBLE TERM LIFE POLICY FOR THE *SIXTH* POLICY YEAR. RATES SHOULD INCLUDE EXPENSE CHARGES AND REFLECT THE EXACT PREMIUM AS PAID BY A CONSUMER. DO NOT LIST RATES PER $1,000.

ISSUE AGE	*UNDER-WRITING	MALE STANDARD PREMIUM	MALE STANDARD DIVIDEND	FEMALE STANDARD PREMIUM	FEMALE STANDARD DIVIDEND
25					
35					
45					
50					

*PLEASE ANSWER BY USING APPROPRIATE LETTER A) MEDICAL EXAM_____ B) QUESTIONNAIRE _____
C) OTHER, EXPLAIN _____.

(EXHIBIT B)
PLEASE RETURN TO:
DIRECTOR OF CONSUMER AFFAIRS
NEW JERSEY DEPARTMENT OF INSURANCE
20 W. STATE STREET
TRENTON, NJ 08625

APPENDIX C

NJ DEPARTMENT OF INSURANCE TERM LIFE QUESTIONNAIRE

PLEASE PROVIDE PREMIUM RATES FOR A $100,000 FACE AMOUNT, ANNUAL, RENEWABLE, CONVERTIBLE TERM LIFE POLICY FOR THE *ELEVENTH* POLICY YEAR. RATES SHOULD INCLUDE EXPENSE CHARGES AND REFLECT THE EXACT PREMIUM AS PAID BY A CONSUMER. DO NOT LIST RATES PER $1,000.

ISSUE AGE	*UNDER-WRITING	MALE STANDARD PREMIUM	MALE STANDARD DIVIDEND	FEMALE STANDARD PREMIUM	FEMALE STANDARD DIVIDEND
25					
35					
45					
50					

*PLEASE ANSWER BY USING APPROPRIATE LETTER A) MEDICAL EXAM_____ B) QUESTIONNAIRE _____
C) OTHER, EXPLAIN _____.

(EXHIBIT C)
PLEASE RETURN TO:
DIRECTOR OF CONSUMER AFFAIRS
NEW JERSEY DEPARTMENT OF INSURANCE
20 W. STATE STREET
TRENTON, NJ 08625

SUBCHAPTER 32. HEALTH SERVICE CORPORATION NOTICE OF INCREASED RATES

Subchapter Historical Note

Subchapter 32 was adopted as R.1989 d.522, effective October 2, 1989. See: 21 N.J.R. 973(b), 21 N.J.R. 3173(c).

11:4-32.1 Purpose and scope

(a) This subchapter outlines the requirements necessary for a health service corporation to increase rates for all hospitalization benefits in response to hospital payment rate increases authorized by the Hospital Rate Setting Commission pursuant to N.J.S.A. 26:2H-4.1.

(b) This subchapter applies only to individual or group contracts of a health service corporation that provide hospitalization benefits which are not experience rated.

(c) This subchapter applies only when a health service corporation can demonstrate that savings in other non-experience rated contract benefits do not offset the payment rate increases authorized by the Hospital Rate Setting Commission.

11:4-32.2 Definitions

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

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

"Contract rates" means those rates charged by a health service corporation to its individual insureds and insured members for non-experience rated products pursuant to filings with the Commissioner under N.J.S.A. 17:48E-27.

"Department" means the New Jersey Department of Insurance.

"Health service corporation" means a health service corporation established pursuant to the Health Service Corporations Act at N.J.S.A. 17:48E–1 et seq., which is organized, without capital stock and not for profit, for the purpose of establishing, maintaining and operating a nonprofit health service plan, and supplying services in connection with the providing of health care or conducting the business of insurance as provided for within the act, or as otherwise subsequently defined by that act.

"Hospital payment rate" means that base rate schedule approved by the HRSC for inpatient and outpatient health care services and delivery in this State, the projected payments of which are utilized by health service corporations, in part, in determining subscriber rates necessary to cover the health service corporation's costs.

"HRSC" means the Hospital Rate Setting Commission established pursuant to N.J.S.A. 26:2H–4.1.

"Notice of Increased Rates" means a filing of notice of rate change with the Commissioner made by a health service corporation following an increase in hospital payment rates by the HRSC. This notice applies only to those contracts issued by a health service corporation which are not experience rated, include hospitalization benefits, are not reflected or anticipated in the health service corporation's contract rates, and are not offset by savings in other benefit provisions under the contract.

11:4–32.3 General provisions

(a) A health service corporation shall file with the Commissioner, and shall forward to the Department of the Public Advocate, Division of Rate Counsel, a Notice of Increased Rates providing, with full documentation, the required information as set forth below:

1. A health service corporation shall provide the date of the most recent filing from which its current rates are effective.

2. A health service corporation shall provide the proposed date of implementation of the increased contract rates.

3. A health service corporation shall identify those lines of business and/or products to which the increased rates apply. These lines of business shall be non-experience rated and provide hospitalization benefits.

4. A health service corporation shall provide all documentation necessary to demonstrate an increase in payment rates authorized by the HRSC.

i. The rate of increase anticipated by a health service corporation as a result of increases in payment rates authorized by the HRSC that exist in the health service corporation's current contract rates must be clearly identified by supporting analysis.

ii. The unanticipated rate of increase as a result of increases in payment rates authorized by the HRSC must be clearly identified by supporting analysis.

5. A health service corporation must demonstrate that no offset of savings exists which have accrued or may accrue to other non-experience rated benefit provisions over the 12–month period commencing with the health service corporation's most recent filing from which its current rates are effective.

6. Savings shown to exist shall be deducted from the health service corporation's documented increase in hospital payment rates; this difference shall be quantified in dollars and shall be apportioned over a 12–month period to non-experience rated contracts which provide hospitalization benefits.

7. A health service corporation shall provide a schedule of rates with respect to those lines of business for which the Notice of Increased Rate filing is made.

(b) A health service corporation shall file with the Commissioner a Notice of Increased Rates if the health service corporation determines that the actions of the HRSC, absent a savings offset, warrant an increase in the health service corporation's contract rates, but in no event shall a Notice of Increased Rates be filed more frequently than once every calendar quarter.

(c) The Notice of Increased Rates may be disapproved by the Commissioner on or before the day the rates are to become effective, which shall be no later than 20 days following the filing of the Notice. If the Commissioner does not disapprove the filing by the end of the 20th day, then the contract rate increase shall be deemed approved.

(d) The Commissioner, in his or her discretion, may waive the 20 day period, or any portion thereof.

(e) A health service corporation is not relieved of its obligation to notify subscribers affected by the rate changes in accordance with its existing contractual notification requirements, and shall comply with all such notification requirements prior to implementation of any rate increase.

11:4–32.4 Inquiries

All questions and correspondence concerning this subchapter should be directed to:

Chief, Service Corporation Compliance Bureau
Division of Actuarial Services
New Jersey Department of Insurance
CN 325
Trenton, NJ 08625

SUBCHAPTER 33. EXCESS INTEREST RESERVE ADJUSTMENT

Subchapter Historical Note

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

11:4–33.1 Purpose

This subchapter establishes procedures for modifying the calculation of excess interest reserves when a life insurer guarantees to credit policy values with interest which exceeds the maximum valuation rate prescribed in N.J.S.A. 17B:19–8. This subchapter does not limit or restrict any other requirement of law.

11:4–33.2 Applicability and scope

This subchapter applies to all life insurance policies, pure endowment and annuity contracts issued by an insurer transacting business in this State in which the insurer has committed to crediting interest to policy values for any period that extends beyond the valuation date at a rate that exceeds the maximum valuation rate as specified and defined in N.J.S.A. 17B:19–8.

11:4–33.3 Requirements

(a) In addition to the basic policy reserve required under N.J.S.A. 17B:19–8, a life insurer is also required by N.J.S.A. 17B:19–8 to establish an excess interest reserve whenever the insurer has committed to crediting interest to policy values for any period of time that extends beyond the valuation date at a rate that exceeds the maximum valuation interest rate.

(b) The amount of the excess interest reserve required equals the total amount of the excess interest commitment, discounted to the valuation date using an interest rate not greater than the maximum rate prescribed under N.J.S.A. 17B:19–8.

(c) Upon written request by an insurer to the Commissioner, the Commissioner may determine that the excess interest reserve calculated on that portion of the policy value encumbered by a policy loan is not required. In making such determination, the Commissioner shall consider the following:

1. The relationship between any minimum guaranteed interest rate, the maximum valuation interest rate and interest rate commitment; and

2. Such other information which the Commissioner deems necessary to make a determination.

11:4–33.4 Separability

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

SUBCHAPTER 34. LONG–TERM CARE INSURANCE

Subchapter Historical Note

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

11:4–34.1 Purpose

The purpose of this subchapter is to implement the insurance laws of this State, to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

11:4–34.2 Applicability and scope

Except as otherwise specifically provided, this subchapter applies to all long-term care insurance policies delivered or issued for delivery in this State on or after the effective date hereof, by insurers; fraternal benefit societies, nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

11:4–34.3 Definitions

Unless the context requires otherwise, the definitions in this section shall apply throughout this subchapter.

"Applicant" means:

1. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and

2. In the case of a group long-term care insurance policy, the proposed certificate holder.

"Certificate" means, for the purposes of these rules, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.

"Commissioner" means the Commissioner of Insurance.

"Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this State and issued to:

1. A group conforming to one of the descriptions set forth in N.J.S.A. 17B:27–2 to N.J.S.A. 17B:27–8 inclusive or N.J.S.A. 17B:27–27.

2. A group other than as described in paragraph 1, subject to a finding by the Commissioner that:

i. The issuance of the group policy is not contrary to the best interests of the public;

ii. The issuance of the group policy would result in economies of acquisition or administration; and

iii. The benefits are reasonable in relation to the premiums charged.

"Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide benefits for not less than 24 consecutive months for such covered person on an expense incurred, indemnity, prepaid or other basis; for one or more medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization. Long-term care insurance shall not include any insurance policy or rider which is offered primarily to provide life insurance coverage, term of care coverage of less than 24 months, basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, mental health or substance abuse coverage, or limited benefit health coverage.

"Policy" means, for the purposes of these rules, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization or any similar organization.

11:4–34.4 Filing requirement

No group long-term care insurance coverage may be offered to a resident of this State under a group policy issued in another state to a group described in paragraph 2 of the definition of "group long-term care insurance" (N.J.A.C. 11:4–34.3), unless the group policy or certificate thereunder has been submitted to and filed by the Commissioner in accordance with the laws and regulations of this State.

11:4–34.5 Policy definitions

(a) No long-term care insurance policy delivered or issued for delivery in this State shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements.

1. "Medicare" shall be 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 Law 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.

2. "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disorder.

3. "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

4. "All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition shall require that the provider be appropriately licensed or certified.

11:4–34.6 Policy practices, provisions and prohibitions

(a) No long-term care insurance policy shall:

1. Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder; or

2. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

3. Provide coverage for skilled nursing care only, or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care, or provide coverage that conditions eligibility for benefits for levels of care on the receipt of higher levels of care; or

4. Require prior institutionalization to condition, limit or restrict eligibility for benefits.

(b) Preexisting condition limitations in long-term care insurance policies or certificates shall not exclude coverage for more than six months after the effective date of coverage under the policy for a condition for which symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment or 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. Nothing, however, shall prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards.

(c) The loss ratio standards set forth in N.J.A.C. 11:4–18.5; the minimum standards provisions set forth in N.J.S.A. 17B:26–45 and N.J.A.C. 11:4–16, 17 and 18; and the reserve requirements set forth in N.J.S.A. 17B:19–5 and N.J.A.C. 11:4–6 are hereby incorporated by reference and shall apply to long-term care insurance, to the extent that such standards, provisions and requirements are not inconsistent with these rules.

(d) Individual long-term care insurance policyholders shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within 30 days of its delivery and to have the premium refunded, if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(e) A certificate issued pursuant to a group long-term care insurance policy delivered or issued for delivery in this State shall include:

1. A description of the principal benefits and coverage provided in the policy;

2. A statement of the principal exclusions, reductions and limitations contained in the policy; and

3. A statement that the group master policy determines governing contractual provisions.

(f) The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language, in accordance with the disclosure requirements of N.J.A.C. 11:4–34.8(a).

1. No such policy issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable."

2. The term "guaranteed renewable" shall be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

3. The term "noncancellable" shall be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(g) No policy shall be delivered or issued for delivery in this State as long-term care insurance, if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except in the case of the following:

1. Preexisting conditions or diseases, in accordance with (b) above and N.J.A.C. 11:4–34.8(d);

2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or any other organic brain disease such as senile dementia;

3. Alcoholism and drug addiction;

4. Illness, treatment or medical condition arising out of:

i. War or act of war (whether declared or undeclared);

ii. Participation in a felony, riot or insurrection;

iii. Service in the armed forces or units auxiliary thereto;

iv. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

v. Aviation (this exclusion applies only to non-fare-paying passengers); or

5. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

6. This subsection is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

(h) Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(i) No policy may be advertised, marketed or offered as long-term care or nursing home insurance unless it complies with the provisions of these rules.

Administrative correction to (g)2.
See: 21 N.J.R. 3777(c).

11:4–34.7 Continuation or conversion of group coverage

(a) Group long-term care insurance issued in this State on or after the effective date of these rules shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due.

(c) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of this group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(d) For the purposes of this section, "converted policy" means a policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. If the policy from which conversion is made restricts provision of benefits and services to named providers or facilities, and the circumstances of termination make continued use of these providers or facilities impossible or impractical, the converted policy shall provide coverage on an indemnity or expense incurred basis with benefits determined by the Commissioner to be substantially equivalent to the reasonable cost of services provided by the named providers or facilities, and shall not restrict provision of benefits and services to any named providers or facilities.

(e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(f) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

1. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

2. The terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:

i. Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

ii. The premium for which is calculated in a manner consistent with the requirements of subsection (f).

(h) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

11:4–34.8 Required disclosure provisions

(a) Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(b) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

(c) A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(d) If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

(e) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility, other than those prohibited by these rules, shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

11:4–34.9 Requirements for replacement

(a) Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and health or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(b) Upon determining that a sale will involve replacement, an insurer (other than an insurer using direct response solicitation methods, or its agent) shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and health or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND HEALTH OR LONG–TERM CARE INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and health or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest, to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

(c) Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and health or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH OR LONG–TERM CARE INSURANCE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and health or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under this new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

11:4–34.10 Discretionary powers of the Commissioner

(a) The Commissioner may, upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of these rules, with respect to a specific long-term care insurance policy or certificate upon a written finding that:

1. The modification or suspension would be in the best interest of the insureds; and

2. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

3. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

11:4–34.11 Outline of coverage

(a) An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall include:

1. A description of the principal benefits and coverage provided in the policy;

2. A statement of the principal exclusions, reductions and limitations contained in the policy;

3. A statement of the renewal provisions, including any reservation in the policy of a right to change premiums; and

4. A statement that the outline of coverage is a summary of the policy issued or applied for, and that the policy should be consulted to determine governing contractual provisions.

(b) The outline of coverage shall be a free-standing document, using no smaller than ten point type.

(c) The outline of coverage shall contain no material of an advertising nature.

(d) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

(e) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(f) The format for the outline coverage shall be as follows:

[COMPANY NAME]
[ADDRESS—CITY & STATE]
[TELEPHONE NUMBER]
LONG–TERM CARE INSURANCE
OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

1. This policy is [an individual policy of insurance] ([group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

i. [Provide a brief description of the right to return—"free look" provision of the policy.]

ii. [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

i. [For agents] Neither [insert company name] nor its agents represent Medicare, the federal government or any state government.

ii. [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

i. [Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

ii. [Institutional benefits, by skill level.]

iii. [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

i. Preexisting conditions;

ii. Non-eligible facilities/provider;

iii. Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

iv. Exclusions/exceptions;

v. Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in paragraph 6.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG–TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

i. That the benefit level will *not increase over time;*

ii. Any automatic benefit adjustment provisions;

iii. Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

iv. If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

v. And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[i. Describe the policy renewability provisions;

ii. For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;

iii. Describe waiver of premium provisions or state that there are not such provisions;

iv. State whether or not the company has a right to change premium and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

11. PREMIUM.

[i. State the total annual premium for the policy;

ii. If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[i. Indicate if medical underwriting is used;

ii. Describe other important features.]

11:4–34.12 Severability

If any provision or clause of this subchapter or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of the subchapter which can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are declared severable.

11:4–34.13 Compliance

Approval of all forms not in compliance with this subchapter is hereby withdrawn as of January 31, 1990. No such form may be issued after this date unless it has been submitted to and filed by the Commissioner subsequent to December 1, 1989, or unless a rider approved subsequent to such date has been attached bringing such form into compliance with this subchapter.

SUBCHAPTER 35. ANNUAL MEDICARE SUPPLEMENT POLICY SURVEY

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17:35C–7 and 17B:26A–7.

Source and Effective Date

R.1991 d.122, effective March 4, 1991.
See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a).

11:4–35.1 Purpose

The purpose of this subchapter is to obtain from insurers the most current and accurate information available with respect to Medicare supplement policies, contracts and certificates delivered in this State. The information will be used to update charts concerning Medicare supplement coverage available in this State, which charts are maintained by the Department of Insurance and distributed upon request.

11:4–35.2 Scope

All insurers providing Medicare supplement coverage in this State shall file with the Commissioner all the information requested by N.J.A.C. 11:4–35.4 for each policy or contract form for which policies, contracts, certificates or evidences of coverage will be or will continue to be delivered or issued for delivery in this State on or after September 1 of the year in which the filing is submitted, except that insurers do not need to file the information for any policy, contract, certificate or evidence of coverage which the insurer will cease to deliver or issue for delivery in this State after December 31 of the year in which the filing is submitted.

11:4–35.3 Definitions

The following words and terms shall have the following meanings when used in this subchapter, unless otherwise indicated:

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

"Department" means the New Jersey Department of Insurance.

"Insurer" means any person, as that term is defined at N.J.S.A. 17B:17–6, engaged in the business of insurance providing Medicare supplement benefits or services, or a combination thereof, to a resident of this State.

"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 for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age. The term does not include:

1. A policy of one or more employee or labor organizations, or of the trustees of a fund established by one or more employee or labor organizations, or a combination thereof, or for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

2. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such policies or contracts are not marketed or held out to be Medicare supplement policies or benefit plans.

"Policy" means any policy, subscriber contract, enrollment contract, certificate or evidence of coverage issued to an individual or group by any health insurer.

11:4–35.4 Filing

(a) Insurers shall file annually with the Department, no later than August 1, of each year, as prescribed by N.J.A.C. 11:4–35.2, a separate copy of the exhibit entitled "Medicare Supplement Policy Survey" for each policy form, which exhibit appears as in the Appendix to this subchapter and is incorporated herein by reference, providing the following information, current as of the date of filing:

1. The insurer name and address;

2. The name, title and telephone number of respondent;

3. The Medicare supplement policy form number;

4. The number of policyholders of that policy form in this State;

5. Current premiums for a male and female at issue age of 65 provided on a monthly basis for that form;

6. A description of the basic policy provisions and/or benefits which shall include an indication of whether coverage is provided for the following:

i. Medicare's Part A deductible amount;

ii. Medicare's co-payment for skilled nursing facility care;

iii. Benefits for skilled nursing facility care beyond that provided by Medicare, and number of additional days of coverage;

iv. Medicare's Part B deductible;

v. Benefits for Part B expenses in excess of Medicare's allowed amounts;

vi. Benefit(s) for a private room in a hospital;

vii. Benefits for care received outside the United States, not otherwise eligible for Medicare reimbursement;

viii. Benefits for private duty nursing;

ix. Benefits for prescription drugs;

x. Medicare's blood deductible; and

xi. Benefits for home health care.

7. An indication of the policy deductible for Medicare Part B expenses;

8. An indication of whether any of the described benefits are optional, and if so, an inclusion of the current additional monthly premium payable to obtain that optional benefit;

9. A statement of whether the insurer offers a policy to people under age 65 who are eligible for Medicare due to a disability, and the form number of such a policy;

10. The telephone number which interested New Jersey consumers may call to obtain additional information or an outline of coverage for that policy form; and

11. The Outline of Coverage made available to current applicants as an attachment to or enclosure with Exhibit B.

(b) Filings made pursuant to (a) above should be submitted to:

SHIP Coordinator
Division of Enforcement and Consumer Protection
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

11:4–35.5 Penalties

Failure to comply with the terms of this subchapter may result in the assessment of penalties in accordance with N.J.S.A. 17B:21–2.

11:4–35.6 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.

APPENDIX

MEDICARE SUPPLEMENT POLICY SURVEY

(Submit completed forms no later than August 1 to: SHIP Coordinator, Division of Enforcement and Consumer Protection, New Jersey Department of Insurance, 20 West State Street, CN 325, Trenton, New Jersey 08625)

(a) Insurer Name: _____

Address: _____

_____

(b) Respondent's Name and Title: _____

Telephone Number: _____

(c) Policy Form Number: _____

Number of New Jersey Policyholders: _____

Current Monthly Premiums: Male/Issue Age 65 $
Female/Issue Age 65 $

	Policy Provisions/Benefits		**If optional, please show add'l monthly premium**
1.	Does policy cover Medicare's Part A deductible?	Y___ N___	$
2.	Does policy cover Medicare's co-payment for skilled nursing facility care?	Y___ N___	$
3.	Does policy provide a benefit for care in a skilled nursing facility not certified by Medicare?	Y___ N___	$
4.	Does policy provide a benefit for care in a skilled nursing facility beyond Medicare's coverage? If so, for how many additional days? _____	Y___ N___	$
5.	Policy deductible for Part B expenses: _____$0 _____$75		
6.	Does policy reimburse Medicare's Part B deductible?	Y___ N___	$
7.	Does policy provide a benefit for Part B expenses in excess of Medicare's allowed amounts?	Y___ N___	$
8.	Does policy provide a benefit for a private room in a hospital?	Y___ N___	$
9.	Does policy provide a benefit for care received outside the U.S. that is not eligible for Medicare reimbursement?	Y___ N___	$
10.	Does policy provide a benefit for private duty nursing?	Y___ N___	$
11.	Does policy provide a benefit for prescription drugs?	Y___ N___	$
12.	Does policy cover Medicare's blood deductible?	Y___ N___	$
13.	Does policy provide benefits for home health care?	Y___ N___	$
14.	Other benefits (attach additional pages if needed):		$ $ $ $ $

(d) Does your company offer a policy to people under the age of 65 who are Medicare eligible due to disability?

If so, please indicate policy form number:

(e) Telephone number for your company where interested New Jersey consumers can call to obtain additional information or an Outline of Coverage:

SUBCHAPTER 36. (RESERVED)

SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

Authority

P.L. 1993, c.162, section 22 (amending P.L. 1992, c.162 (N.J.S.A. 17B:27A–17 et seq.)), N.J.S.A. 17:1C–6 and 17B:21–1 et seq.

Source and Effective Date

R.1994 d.45, effective January 18, 1994.
See: 25 N.J.R. 4554(b), 26 N.J.R. 381(a).

11:4–37.1 Purpose and scope

(a) The purpose of this subchapter is to set forth standards and procedures whereby a carrier shall obtain approval from the Commissioner of its offering of health benefits plans utilizing selective contracting arrangements that promote health care cost containment while adequately preserving quality of care.

(b) This subchapter applies to all carriers operating pursuant to Title 17B of the New Jersey statutes, and issuing health benefits plans utilizing selective contracting arrangements in this State or which cover New Jersey residents. This subchapter shall not apply to the following: hospital service corporations operating pursuant to N.J.S.A. 17:48–1 et seq.; medical service corporations operating pursuant to N.J.S.A. 17:48A–1 et seq.; hospital and medical service corporations operating pursuant to N.J.S.A. 17:48B–1 et seq.; dental service corporations operating pursuant to N.J.S.A. 17:48C–1 et seq.; dental plan organizations operating pursuant to N.J.S.A. 17:48D–1 et seq.; or health service corporations operating pursuant to N.J.S.A. 17:48E–1 et seq.

11:4–37.2 Definitions

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

"Allowable expense" means the usual, customary and reasonable item of expense for a covered service when the item of expense is covered at least in part by the health benefits plan.

"Carrier" means any insurance company operating pursuant to Title 17B of the New Jersey statutes and authorized to issue health benefits plans in this State.

"Coinsurance" means the percentage of the allowable expenses payable by the covered person.

"Coinsurance differential" means the difference in the coinsurance percentage applicable to in-network and out-of-network benefits.

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

"Copayment" means a specified dollar amount a covered person must pay for specified covered services.

"Covered person" means a person on whose behalf the carrier is obligated to pay benefits pursuant to the health benefits plan.

"Covered service" means a service provided to a covered person under a health benefits plan for which a carrier is obligated to pay benefits.

"Department" means the New Jersey Department of Insurance.

"Emergency care" means covered services that are provided by any health care provider, which are needed immediately because of an injury or sudden illness and the time required to reach a preferred provider would have meant serious deterioration of or risk of permanent damage to the covered person's health. These services are considered to be emergency care as long as transfer of the covered person to a preferred provider is precluded because of risk to the covered person's health or because transfer would be unreasonable, given the distance involved in the transfer or the nature of the medical condition.

"Evidence of coverage" means any booklet, certificate, agreement or contract issued to covered persons setting out the services and other benefits to which they are entitled under a health benefits plan.

"Health benefits plan" means a policy or contract delivered or issued for delivery in this State by a carrier paying benefits for covered services.

"Health care provider" means an individual or entity which, acting within the scope of its licensure or certification by the Department of Health, provides a covered service defined by the health benefits plan.

"Preferred provider" means a health care provider or group of health care providers who have entered into selective contracting arrangements with a carrier or a preferred provider organization.

"Preferred provider organization" or "PPO" means an entity other than a carrier that contracts with preferred providers to establish selective contracting arrangements.

"Selective contracting arrangement" means an arrangement for the payment of predetermined fees or reimbursement levels for covered services by the carrier to preferred providers or preferred provider organizations.

11:4–37.3 Standards for selective contracting arrangements

(a) For purposes of paying for covered services under a health benefits plan, a selective contracting arrangement entered into by a carrier shall meet the following criteria:

1. The selective contracting arrangement shall include a mechanism for the review or control of utilization of covered services;

2. The selective contracting arrangement shall provide for an adequate number of preferred providers by specialty to render covered services in the geographic service area(s) where it functions;

3. The selective contracting arrangement shall include a procedure for resolving complaints and grievances of covered persons;

4. The selective contracting arrangement shall provide that information pertaining to the diagnosis, treatment or health of any covered person receiving health care benefits shall be confidential and shall not be disclosed to any person except as follows:

i. To the extent that it may be necessary to carry out the purposes of this subchapter;

ii. Upon the express consent of the covered person;

iii. Pursuant to statute or regulation;

iv. Pursuant to court order for the production of evidence or the discovery thereof;

v. In the event of a claim or litigation between such covered person and the carrier wherein such data or information is pertinent; or

vi. As otherwise required by law.

(b) Health benefits plans utilizing selective contracting arrangements shall meet the following criteria:

1. The health benefits plan utilizing a selective contracting arrangement shall provide that covered persons shall not be held financially liable for payments to health care providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered services, if the carrier fails to pay for the covered services for any reason.

2. If a covered person is in need of emergency care as defined herein, the health benefits plan utilizing a selective contracting arrangement shall include a mechanism which reimburses emergency care as if the covered person had been treated by a preferred provider;

3. The carrier shall, within 30 days of delivering a health benefits plan utilizing a selective contracting arrangement, provide covered persons with evidence of coverage which shall contain provisions or statements which are not unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation. The evidence of coverage shall contain either a clear and complete statement or a reasonably complete summary of:

i. The insurance or other benefits, if any, to which covered persons are entitled;

ii. Any limitation on the benefits, or kind of benefits, to be provided, including the coinsurance differential for services rendered by a preferred provider as opposed to a non-preferred provider, as well as any copayment, deductible or coinsurance feature;

iii. Information as to where and in what manner services or benefits may be obtained; and

iv. A clear, accurate and understandable description of the method for resolving complaints from covered persons;

4. The carrier issuing health benefits plans utilizing a selective contracting arrangement shall provide that subsequent changes in coverage shall be evidenced in a separate document issued to the covered person;

5. The carrier utilizing a selective contracting arrangement may provide in its health benefits plan for direct payment to the preferred provider for covered services rendered, and shall establish either the methodology to determine the amount or the actual amount of payment to the preferred provider whichever is applicable;

6. The carrier utilizing a selective contracting arrangement for a health benefits plan shall include a mechanism which provides that the coinsurance differential, if any, applicable to covered services rendered by a preferred provider, as opposed to covered services rendered by other health care providers, shall be no greater than 30 percent of the allowable expense, provided deductibles and copayments are equivalent for both in-network and out-of-network benefits. If deductibles and copayments for in-network and out-of-network benefits are not equivalent, the 30 percent maximum coinsurance differential shall be adjusted to reflect the differences. The mechanisms for the delivery of a health benefits plan utilizing a selective contracting arrangement established by either the Individual Health Coverage Program Board of Directors or the Small Employer Health Benefits Program Board of Directors on or before January 1, 1994, will be deemed to meet this requirement.

(c) Nothing contained in this subchapter shall be deemed to impair or otherwise affect any selective contracting arrangements, collective bargaining agreements, or health benefits plans which have been filed and approved by the Commissioner and which were in effect before June 1, 1993, except as they may be renewed on or after June 1, 1993.

1. All selective contracting arrangements entered into or renewed on or after June 1, 1993, other than those which provide benefits under a collective bargaining agreement, shall be brought into full compliance with the

requirements of this subchapter as they renew but no later than April 18, 1995.

2. Any selective contracting arrangement entered into or renewed on or after June 1, 1993, which provides benefits under a collective bargaining agreement, shall be brought into full compliance with the requirements of this subchapter either on or before January 1, 1995 or within 90 days after the expiration of the term of the collective bargaining agreement, whichever is later.

3. Every carrier with selective contracting arrangements subject to this subsection shall submit to the Department by April 18, 1994, a Plan of Compliance, setting forth the methods and timetable the carrier will follow in bringing its current selective contracting arrangements into full compliance with this subchapter.

4. Carriers shall submit five copies of the Plan of Compliance described in (b)3 above, together with the filing fee set forth at N.J.A.C. 11:4–37.9, to the Department as specified at N.J.A.C. 11:4–37.5(a).

11:4–37.4 Selective contracting arrangement approval procedures

(a) No carrier shall issue health benefits plans utilizing selective contracting arrangements unless the carrier has entered into such arrangements directly with preferred providers or has contracted with preferred provider organizations.

(b) For purposes of obtaining the Commissioner's approval under this subchapter, a carrier issuing health benefits plans utilizing a selective contracting arrangement shall submit five copies of the selective contracting arrangement approval application on a form to be provided by the Department. The items set forth at (b)13 and 14 below shall be set forth separately from the remainder of the items to be included in the approval application.

1. Three copies of the entire application, together with the appropriate filing fee set forth at N.J.A.C. 11:4–37.8, shall be submitted to the Department at the following address:

New Jersey Department of Insurance
Managed Health Care Bureau
Division of Life/Health Actuarial Services
20 West State Street
CN 325
Trenton, NJ 08625

2. Two copies of the entire application, together with the appropriate filing fee set forth at N.J.A.C. 11:4–37.8, shall be submitted to the Department of Health at the following address:

New Jersey Department of Health
Alternative Health Systems Program
300 Whitehead Road
CN 367
Trenton, NJ 08625

(c) The selective contracting arrangement approval application shall include the following:

1. A narrative description of the health benefits plan to be offered;

2. A statement that the carrier is entering into a selective contracting arrangement directly with preferred providers, or where the carrier is contracting with a PPO, a description of the PPO that will operate and/or administer the selective contracting arrangement; a description of the relationship between the carrier and the PPO; and a certification signed by a senior officer of the PPO that the PPO does not engage in the business of insurance in this State, and in no way assumes risk in the provision of services for the treatment of injury or illness or preventative care for any person or on behalf of any person other than its own employees;

3. A description of the geographical service areas in which the health benefits plan is to be offered;

4. A description of the manner in which covered services and other benefits may be obtained by covered persons using the selective contracting arrangement;

5. A narrative description of the financial arrangements between the carrier and the preferred providers if the carrier is contracting directly with the preferred providers, or between the carrier and the PPO if the carrier is contracting with a PPO;

6. A copy of every standard form contract, including variables, establishing the selective contracting arrangements that will be utilized in the health benefits plan, including the standard contract(s) or agreement(s) the carrier or PPO has entered into with health care providers or classes of health care providers;

7. A description of the criteria and method used to select preferred providers, including any credentialing plan;

8. The names and addresses of preferred providers, by specialty and geographic service areas, and a copy of the provider directory to be distributed to covered persons;

9. A description of any provisions which allow covered persons to obtain covered services from a health care provider that is not a preferred provider;

10. A description of the utilization review program. At a minimum this shall include:

i. A description of the criteria and methods to be used in utilization control, particularly the criteria for determining over- and under-utilization; and

ii. A description of the mechanisms for evaluating the success or failure of the utilization review program;

11. A description of the quality assurance program. At a minimum this shall include:

i. A clear description of how quality of care will be monitored and controlled;

ii. The criteria used to define and measure quality;

iii. The criteria used to determine the success or failure of the quality assurance program; and

iv. A description of the staff and their qualifications that will be responsible for the quality assurance program;

12. A description of the complaint and grievance system available to covered persons, including procedures for the registration and resolution of grievances;

13. A copy of every standard form policy or contract, including variables, to be issued by the carrier to the contractholders of health benefits plans, which shall include the requirements set forth at N.J.A.C. 11:4–37.3(b)3;

14. A copy of every standard form of evidence of coverage to be issued by the carrier to covered persons, setting forth the carrier's contractual obligations to pay for covered services provided to covered persons, which shall include the requirements set forth at N.J.A.C. 11:4–37.3(b)3;

15. A description of the incentives for covered persons to use the services of preferred providers;

16. A description of the provisions within the health benefits plan for holding covered persons financially harmless for payment denials by, or on behalf of, the carrier for improper utilization of covered services caused by preferred providers;

17. An organizational chart of the carrier's division responsible for managing selective contracting arrangements and of the PPO if appropriate;

18. A listing and biography of the officers and directors, if any, of the carrier's division responsible for managing selective contracting arrangements and of the PPO if appropriate;

19. The address of the place of business of the carrier's division responsible for managing selective contracting arrangements and of the PPO if appropriate;

20. A copy of the PPO's most recent financial statement if the carrier is contracting with a PPO; and

21. The following three-year pro-forma information concerning the benefit plans to be issued utilizing selective contracting arrangements:

i. Enrollment projections indicating the number of employees by rating status (that is, single, husband/wife, parent/child and family) and number of covered persons. This data is to be provided quarterly for the first year, and annually for the remaining two years; and

ii. Financial projections, including balance sheet, income and expense statement and a cash-flow statement.

(d) Any significant changes to the nature of the selective contracting arrangement as reflected in the materials in (a) above shall be reported to the Department within 30 days, at the following address:

New Jersey Department of Insurance
Managed Health Care Bureau
Division of Life/Health Actuarial Services
20 West State Street
CN 325
Trenton, NJ 08625

(e) The Commissioner, in consultation with the Commissioner of Health as necessary, shall review these documents and grant approval, within 30 days of the carrier's filing its application for approval, to those carriers whose selective contracting arrangements are determined to meet the criteria set forth in this subchapter and which promote health care cost containment while adequately preserving quality of care. The Commissioner may extend the 30–day time frame an additional 30 days for good cause shown and shall provide notice to the carrier of such extension. A decision to deny approval shall be accompanied by a written explanation by the Department of the reasons for denial. A carrier whose selective contracting arrangement has been denied approval may request an administrative hearing pursuant to the procedures at N.J.A.C. 11:4–37.6.

(f) The approval of a selective contracting arrangement issued under this subchapter by the Commissioner, in consultation with the Commissioner of Health, shall remain in force for a period of three years excepting suspension or revocation pursuant to this subchapter.

(g) A carrier shall apply for triennial renewal of the Department's approval of its selective contracting arrangement at least 60 days prior to the expiration of the previous three-year approved period. Applications for renewal of the Department's approval shall be subject to the filing fee set forth at N.J.A.C. 11:4–37.9. If the Department has not issued a written notice of disapproval, which clearly sets forth the reasons for disapproval of the renewal application, within 60 days of receipt of the renewal application, the renewal application shall be deemed approved.

11:4–37.5 Confidentiality

(a) The following data or information submitted to the Department under this subchapter shall not be confidential and may be released by the Department and the Department of Health, but only upon written, specified request:

1. The carrier's narrative description of the health benefits plan to be offered;

2. The carrier's description of the geographical service area in which the carrier will offer the health benefits plan;

3. The carrier's description of the manner in which covered services and other benefits may be obtained by covered persons under the selective contracting arrangement;

4. The names and addresses of the selective contracting arrangement's or PPO's preferred providers, by specialty and geographic service areas, and the provider directory;

5. The carrier's description of any provisions included in the selective contracting arrangement which allow covered persons to obtain covered services from a health care provider that is not a preferred provider;

6. The carrier's description of the complaint and grievance system available to covered persons under the selective contracting arrangement;

7. Copies of the standard form policy or contract to be issued by the carrier to the contractholders of health benefits plans;

8. Copies of the standard evidence of coverage form to be issued by the carrier to covered persons;

9. The carrier's description of the incentives for covered persons to use the services of preferred providers;

10. The carrier's description of the provisions within the health benefits plan for holding covered persons financially harmless for payment denials by or on behalf of the insurer for improper utilization of covered services caused by preferred providers;

11. The PPO's most recent financial statement;

12. The PPO's certification that it does not engage in the business of insurance in this State or assume risk in the provision of services for the treatment of injury or illness or preventative care for any person or on behalf of any person, other than its own employees;

13. The carrier's or PPO's organizational chart;

14. The carrier's or PPO's listing and biography of its officers and directors;

15. The address of the carrier's or PPO's place of business; and

16. The address of the carrier's division responsible for managing selective contracting arrangements.

(b) All data or information submitted to the Department under this subchapter, except for those items included in (a) above, is confidential and shall not be disclosed by the Department to any person other than employees and representatives of the Department and the Department of Health.

11:4–37.6 Approval denial, suspension and revocation

(a) The approval of a selective contracting arrangement issued by the Department under this subchapter may be denied, suspended or revoked if the Commissioner determines that:

1. The selective contracting arrangement criteria set forth in this subchapter are not being met;

2. Payment for covered services provided under the selective contracting arrangement is not in accordance with the terms of the approved arrangement;

3. The arrangement for the payment of covered services fails to meet the requirements of these rules; or

4. Any false or misleading information is submitted by the carrier seeking approval.

(b) If the Commissioner believes that any of the conditions set forth in subsection (a) above exist, the Commissioner shall notify the carrier by directing a notice by certified mail or personal delivery to the last known business or mailing address of the carrier. The notice shall include:

1. A description of the condition(s) in (a) above alleged to exist;

2. A statement that the carrier may within 20 days correct the condition(s) alleged to exist; and

3. A statement advising the carrier of the procedure for requesting a hearing.

(c) A carrier requesting a hearing pursuant to (b)3 above shall submit the hearing request to the Department at the following address:

New Jersey Department of Insurance
Managed Health Care Bureau
Division of Life/Health Actuarial Services
20 West State Street
CN 325
Trenton, NJ 08625

The hearing request shall include:

1. The name, address and telephone number of a contact person familiar with the matter;

2. A copy of the Commissioner's written allegations;

3. A statement requesting a hearing; and

4. A concise statement describing the factual and legal bases for which the carrier believes that the Commissioner's allegations are erroneous; and

5. All relevant documents in support of the hearing request.

(d) The Commissioner may, after receipt of a properly completed request for a hearing, provide an informal conference between the carrier and such personnel of the Department or Department of Health as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

(e) The Commissioner shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

1. If the Commissioner concludes that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

2. In a matter which has been determined to be a contested case, if the Commissioner concludes that there are no good-faith disputed issues of material fact and the matter may be decided on the documents filed, the Commissioner may notify the carrier in writing of the final disposition of the matter.

(f) In addition, or as an alternative to suspension or revocation, the Commissioner may impose such other penalties as provided by law.

11:4–37.7 Monitoring; auditing

(a) The Commissioner, in consultation with the Commissioner of Health as necessary, shall monitor and conduct periodic audits or examinations of the carrier's selective contracting arrangements as necessary to ensure compliance with the approval criteria set forth in this subchapter.

(b) All records of the carrier relating to selective contracting arrangements shall be disclosed upon request of and in a format acceptable to the Commissioner. If such records are maintained in a coded or semi-coded manner, a legend for the codes shall be provided to the Commissioner.

11:4–37.8 Filing and review fees

(a) Every carrier shall pay a $3,000 filing fee for filing each of the following with the Department:

1. A selective contracting arrangement pursuant to N.J.A.C. 11:4–37.4;

2. A plan of Compliance pursuant to N.J.A.C. 11:4–37.3(b);

3. A triennial renewal application of a selective contracting arrangement pursuant to N.J.A.C. 11:4–37.4(g).

(b) The approval application, renewal application and Plan of Compliance fees of $3,000 shall be payable as follows:

1. $1,500 payable to the "Treasurer, State of New Jersey."

2. $1,500 payable to the "New Jersey Department of Health."

(c) Every carrier, in addition to complying with the filing and review fee requirements set forth in this section, shall be subject to any fees that may be applicable as set forth in N.J.A.C. 11:1–32.

APPENDIX TO SUBCHAPTERS 16 AND 23

EXHIBIT A

BRIDGING THE MEDICARE GAPS: A GUIDE TO MEDICARE SUPPLEMENTS

INTRODUCTION

Medicare. The word can be both a comfort and a puzzle. A comfort because Medicare is a program which provides good, basic health coverage at minimal cost. A puzzle because the program's structure makes it look harder to understand than it really is.

Medicare historically has paid a relatively stable share of health care costs for older citizens, ranging from about 40 percent in 1977, 45 percent in 1984 and 40.1 percent in 1988, according to the U.S. House of Representatives Select Committee on Aging.

But health care costs have been rising faster than inflation—which means higher medical bills. So even though older people have been paying a relatively constant percentage of their medical bills, the bills themselves are larger. The bottom line is that older citizens are paying more total dollars for their share of health care costs.

Before making a decision about which insurance coverage to buy to supplement Medicare, everyone should do two things. First, know what Medicare does and does not cover. Second, assess his or her own needs and financial situation.

Assessing the need for additional protection is easier if one understands the basic structure of Medicare. The first part of this booklet is designed with that in mind. The rest of this booklet will tell you what other types of insurance are available to fill some of Medicare's gaps.

MEDICARE

What Is It?

Medicare is a federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. The program is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services. The Social Security Administration provides information about the program. Persons who are not automatically enrolled in Medicare may enroll at their local Social Security Office.

Basic Structure of Medicare

Medicare coverage comes in two parts—Part A, hospital insurance, and Part B, medical insurance.

The two parts of the program parallel the division in the medical community between hospitals and physicians. Although hospitals are filled with doctors, few doctors actually work for hospitals. Most physicians are independent business people. So, if you go to the hospital with the flu, you receive separate bills—one for the things the hospital provides such as a room, nurses, food and drugs; and another for the doctors who treat you. Similarly, Medicare has two parts—A, which pays inpatient hospital bills, and B, which pays doctors' bills and other outpatient medical expenses.

Part A, the hospitalization portion of Medicare, is funded for most individuals through employee contributions to FICA taxes while they are employed. This amount goes into the Part A trust fund and pays for the Part A premiums for most people. A very small percentage of seniors must purchase Part A and pay a monthly premium. This includes persons who have not contributed sufficiently to FICA taxes while employed; those who have not worked and do not have a spouse who has contributed to the Social Security system; and, persons from outside the country who have lived in the United States for five or more continuous years.

Individuals who purchase the hospital insurance (Part A) coverage are also required to purchase medical insurance (Part B).

Those who must pay for, but cannot afford Medicare's premiums should contact their local Social Security Office or Board of Social Services, since they may qualify for other assistance programs.

Persons already receiving monthly Social Security or Railroad benefits receive their Medicare card automatically without the need to file an application. All others must file an application in order to be covered by Medicare.

Part B, the medical portion, is paid for by the consumer on a monthly basis, which, for most people, is deducted from their Social Security check. You are automatically enrolled in Part B when you enroll in Part A, unless you specifically state you do not want it. If you choose not to enroll in Part B when you sign up for Medicare, you can join this portion of the program later. However, if for some reason you choose to wait to sign up for Part B, the Medicare premiums may be higher. Persons who wait because they or their spouse are still working and covered under the employer's group health plan, will not have to pay the higher Part B premium if they sign up within seven months of the date when employment ceases.

Each of the two parts has a deductible, an amount you have to pay before Medicare starts paying.

Each also requires a copayment, that part of each bill you are required to pay.

And each has its own rules about when these payments are required. The specific dollar amounts can change from year to year. The chart in the back pocket of this booklet shows this year's deductible and co-payment amounts.

Medicare Part A—Hospital Insurance

The hospital insurance portion of Medicare, Part A, pays hospital room and board fees. It also pays for some goods and services (such as laboratory costs, physical therapy and prescription medications) while you're a patient in the hospital.

Part A does not cover all hospital bills. It covers a portion of them, depending on how long you are in the hospital, and on the basis of benefit periods, which determine the number of days of coverage you still have available. (See a discussion of benefit periods on page ___.)

Drawn on a graph like the one on page ___, the system resembles a three-step staircase. First you pay the Part A hospital deductible (which is roughly equal to the average national cost of one day in a hospital).

Then, for 60 days, Medicare pays 100 percent of the covered hospital expense.

After 60 days, you take the first step down. For days 61 through 90, Medicare covers most of the hospital bills, but you have to pay a co-payment for each day you are there. (The co-payment is about 25 percent of the average national cost of a day in the hospital.)

If, after the 90 days, you are still in the hospital, you have to make a decision. You either begin paying all the hospital bills yourself, or you take a half-step and dip into the lifetime reserve days that Medicare provides.

Your lifetime reserve is a "bank" with 60 days of partial coverage. The daily co-payment rises to about 50 percent of the average national daily hospital charge. You can use all or some of the 60 days for any hospitalization between 91 and 150 days. Once you use up all 60 lifetime reserve days, however, you cannot get them back.

Although the increases in co-payments may seem steep, the odds of experiencing a prolonged hospital stay are small. Only 2 percent of Medicare subscribers exhaust their coverage in any given year, according to HCFA. In fact national statistics indicate that the average hospital stay for a person with Medicare is approximately 14 days.

Additional Part A Coverage

Medicare also pays for three of the newer, less expensive alternatives to hospitalization—skilled nursing facility care, home health care and hospice care.

Suppose, for example, you have had a stroke and have been in the hospital for several weeks. You no longer need the intensive care a hospital provides, but you do need rehabilitative therapy on a daily basis before going home. Your doctor may refer you to a skilled nursing facility, where you will get professional nursing care and rehabilitation services. Although there are some restrictions, Medicare will generally pay all the facility's bills for the first 20 days and a portion of the bills for days 21 through 100, providing the care is reasonable and necessary.

Medicare will also pay for covered home health care services, if your condition meets certain requirements, such as a need for part-time skilled nursing care, physical therapy or speech therapy while homebound.

In addition, Medicare covers hospice care for terminally ill patients who want to stay home during their final weeks of life. Hospices (special organizations which help dying patients and their families) will supply doctors' services, nursing care, home health aides, homemaker services, counseling, and medical appliances and supplies. There are some restrictions and some minimal co-payments for a few services, but Medicare will pick up the majority of the bills.

How Often Can You Collect?

Medicare Part A pays hospital expenses on the basis of benefit periods. A benefit period starts when you enter a hospital and ends when you have been out of the hospital or skilled nursing facility for 60 days in a row.

Benefit periods determine whether you have to pay a deductible and how much of the hospital bill Medicare will pay. For instance, suppose you were in the hospital 60 days, went home for two weeks and then went back to the hospital for another two weeks. You would only have to pay one deductible because both hospitalizations occurred in the same benefit period. You would, however, have to pay a co-payment for each day of the two weeks you were hospitalized the second time, because you exhausted your 100 percent coverage during the first 60 days of the benefit period.

When Will Medicare Refuse to Pay?

As you may already know, there are several levels of nursing home care: skilled, intermediate and custodial.

Medicare covers services only at the skilled level in Medicare-approved skilled nursing care facilities, which are sometimes called nursing homes. Persons at this level require daily skilled, professional care which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis.

Medicare does not cover care at the intermediate or custodial care levels. The reason is that persons receiving care at these levels are provided only intermittent professional care or only a place to live and help with personal

needs such as bathing, feeding, dressing and taking medicine.

You should be aware of the fact that Medicare pays hospitalization, skilled nursing facility and home health care agency fees only for Medicare-approved facilities or agencies. All New Jersey hospitals are Medicare-approved, but some hospitals and treatment centers in other states may not be. Also, note that although a skilled nursing facility or home health care agency is licensed by the state, it may not be Medicare-approved.

Medicare may also refuse to pay for experimental or controversial procedures.

Except under certain very limited conditions in Canada and Mexico, Medicare will not cover care received outside the United States.

If you plan to travel, or if you are not sure whether the treatment or hospital you are considering has Medicare approval, check ahead of time with your local Social Security Office to see if benefits are available.

Medicare Part B—Medical Insurance

Medicare Part B, medical insurance, is the portion that helps to pay your doctor, whether you are in or out of the hospital. It also serves as a catch-all for the wide-range of services people use when they are not patients in hospitals—such as outpatient visits to hospitals, physical therapy, laboratory tests, medical equipment (like wheelchairs or oxygen), and medically necessary home health care visits.

The medical insurance portion, Part B, has an annual deductible, an amount which you must pay once each year before Medicare will pay any bills related to Part B. The chart in the pocket on the back page shows the deductible amount for this year.

How Much Does It Pay?

The medical insurance portion of Medicare was designed to pay 80 percent of the cost of most covered services. You pay the other 20 percent, which is the Part B co-payment.

However, you could wind up paying more than 20 percent. Fees charged by doctors, therapists, suppliers and hospitals may vary, even within one town. But Medicare has a fixed schedule of fees, known as the "approved amount," for procedures done in your area. Medicare will pay only 80 percent of the approved amount. So, if your bill from the doctor or hospital outpatient clinic is higher than the approved amount, you are responsible for the difference.

Example: Suppose the Medicare-approved amount for a medical procedure is $100, but your doctor charges you $110. Medicare will pay 80 percent of the $100 approved amount, or $80; you pay the 20 percent co-payment, or $20. But you also must make up the difference between the $110 bill and Medicare's $100 approved amount ($10). So the total out-of-pocket cost to you is $30.

Some doctors "accept assignment." This means the doctor agrees to accept the Medicare-approved amount for the services provided. After Medicare pays its portion of the approved amount, 80 percent, you are responsible for the balance, the 20 percent co-payment.

Some doctors accept assignment some of the time; some accept it all the time; and, others never accept it. Find out, before treatment, whether your doctor will accept assignment. Each year, doctors and medical service suppliers can sign agreements to become Medicare-participating doctors or suppliers. This means they agree in advance to accept assignment for all Medicare claims. The "Medicare–Participating Physician/Supplier Directory", which is available in Social Security offices and county Offices on Aging, gives the names and addresses of Medicare-participating doctors and suppliers. You can also get this free directory from Pennsylvania Blue Shield, the Medicare carrier for New Jersey.

For a detailed description of the Medicare program, ask your local Social Security office for a free copy of "Your Medicare Handbook."

FILLING IN THE GAPS

By now you are aware that Medicare coverage has three general gaps:

1. the deductibles and co-payments;
2. the difference between what Medicare pays and what the doctor charges; and
3. the services and items which Medicare does not cover at all (for example: most nursing home care, prescription drugs, hearing aids, care outside the U.S., etc.).

Consumers attempt to fill these gaps in a variety of ways. There are different policies and medical assistance programs which fill gaps in Medicare coverage. Some of these are outlined in the following sections of this booklet. It is important to note, however, it isn't likely you will find one type of coverage, or combination of coverage, that will fill all of Medicare's gaps.

The word "medigap" is an umbrella term. This means that it does not refer to any one specific type of insurance, but rather to several kinds of insurance that may help to fill in some of the gaps in Medicare. Following are different kinds of coverage that consumers often consider adding to their Medicare coverage.

To decide which type of insurance coverage suits you best, begin by evaluating your needs and financial circumstances. You should first decide how much you can afford to pay for insurance. Then decide which benefits are important to you, for example, "first dollar" coverage that will pay Medicare's deductibles and co-payments; or, perhaps you are more concerned about having benefits for things that Medicare does not cover, such as doctors' bills that go beyond the Medicare-approved amount or care outside the United States; or, perhaps you would find it easier to budget regular insurance payments than to worry about future medical bills which you might not be able to pay.

Medicaid

For some people, having to pay even small amounts for medical expenses or another health insurance policy may be a real hardship. If you are one of them, check with your local Social Security Office or County Board of Social Services/Welfare Agency to see if you are eligible for Medicaid a free health care program for low-income people funded by the state and federal governments.

Points to Consider. Although the combination of Medicare and Medicaid pays many of your health care costs, you should consider the following points before discontinuing any Medicare supplement coverage you may already have:

1. a Medicare supplement policy may cover services not paid by Medicaid, such as private duty nursing, care outside the United States or a private room in a hospital;

2. if your Medicaid eligibility ends, and you apply for a Medicare supplement policy, the insurer may require that you wait up to six months before a new policy will pay benefits for health conditions you already have;

3. if you enter a nursing home, Medicaid will pay the premium for your Medicare supplement policy;

4. if you cancel Medicare supplement coverage that has been available to you at no charge as a retirement benefit or through your spouse's employer group health plan, it may not be renewable if you no longer qualify for Medicaid.

If you purchased a Medicare supplement policy on or after November 5, 1991, and you have since become eligible for Medicaid, there is a recent federal law which applies to you.

The law requires that, at your request and as long as you are entitled to Medicaid, the insurance company must suspend your Medicare supplement policy benefits and premiums for up to a two year period. Also, the insurer must reinstate your Medicare supplement coverage, upon your request, if your entitlement to Medicaid ends during that time.

Other State Assistance Programs

New Jersey has a variety of health care programs available to certain needy residents who may not qualify for the traditional Medicaid Program. Each program has its own eligibility requirements. Contact your County Welfare Agency or Board of Social Services to see if you qualify for any of the following:

New Jersey Care

Medically Needy

Community Care Program for the Elderly and Disabled (CCPED)

AIDS Community Care Alternative Program (ACCAP)

State Assistance Programs for Prescriptions and Hearing Aids

Outpatient prescription medications are not generally covered under Medicare. The exception is that Medicare pays a percentage of the costs for immunosuppressive drugs, for one year, following an organ transplant.

New Jersey has a program that will help pay for prescription drugs, and another that will help pay for hearing aids. Both programs require applicants to meet certain eligibility criteria.

The Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program helps pay for prescription medicines and some pharmacy items such as insulin syringes and needles.

The Hearing Aid Assistance to the Aged and Disabled (HAAAD) Program reimburses $100 to eligible residents of New Jersey who buy a hearing aid.

To qualify for PAAD or HAAAD, you must be at least 65 or be receiving Social Security Disability and you must meet certain income limits. The limits, which are higher than those for Medicaid, can change.

For more information about the prescription or hearing aid program call the toll-free hotline at 1–800–792–9745.

What Does Your Employer Offer?

The ideal time to start thinking about how you will supplement Medicare is several months before you reach age 65, particularly since you may be able to take advantage of insurance coverage you have as an employee.

If you are covered by a health plan at work, your employer may allow you to remain insured under the group plan after you retire and continue to pay all or part of the premium. This is sometimes referred to as "continuation."

Your employer may offer a different arrangement called "conversion." This permits you to buy an individual policy from the same insurance company you had at work, but does not necessarily mean your new policy will have the

same benefits. Nor does it mean the policy will be cheaper than policies you may find by shopping around on your own.

Continuation and conversion offer two advantages: you will probably not be required to produce a medical history or undergo a medical examination; and, you will not have to wait to receive benefits.

One kind of insurance you may be able to maintain through continuation or conversion is a major medical policy.

As the name implies, major medical coverage is designed to cover very large medical bills, usually after you have paid a substantial deductible. The deductibles for major medical can be as high as $1,000 or more, depending on the policy, but the coverage can amount to as much as $1 million.

Continuation of a major medical plan through a former employer may help pay for some costs after Medicare stops paying or for costs Medicare will not pay at all—for example, medical bills that exceed the Medicare allowed amount.

There are no hard and fast rules about continuation or conversion policies. Ask your employer's personnel office to explain your options. Be sure to discuss whether you can continue or convert; how much the coverage will cost; whether the policy will cover your spouse (some do and some do not); and what benefits are included in the plan.

If you are required to pay some or all of the premiums for your retirement health benefits, you may find it to your advantage to shop around for less expensive health insurance which will adequately supplement your Medicare coverage.

Health Maintenance Organizations

Membership in a health maintenance organization—HMO—is another way to fill the gaps in Medicare. HMOs are prepaid health care programs. Like insurance policies, HMOs cover certain health care costs. Unlike insurance policies, HMOs actually provide health care services. Some HMOs have a contract with Medicare. As a Medicare beneficiary, you are eligible to join an HMO if you participate in both Parts A and B of Medicare and live in a county where an HMO that contracts with Medicare is available. Persons with Part B only of Medicare are also eligible to enroll in a Medicare-contracting HMO, however, coverage is limited.

If you join an HMO, you do not have to pay the Medicare deductibles or co-payments or file claims. You pay a monthly premium to the HMO, which provides doctors' services and most other health care. You may have to pay a co-payment of $1 to $10 for some services.

The trade-off is that you have to use the HMO participating doctors and facilities. If you need a specialist, you must go to one recommended by the HMO. If you choose to see a non-HMO physician on your own, you may have to pay all or some of the bills yourself.

HMOs can have one of two types of contracts with Medicare: either a "cost" or a "risk" contract. You should learn which type of contract the HMO has with Medicare before enrolling.

Members of an HMO having a cost contract with Medicare have a bit more flexibility with regard to reimbursement when they choose to go outside of the HMO network. The reason is that when Medicare has a cost contract with an HMO, it will still pay 80 percent of its approved amount for services rendered to a member out of the HMO network.

When Medicare has a risk contract with an HMO, however, it will not pay any portion of the bill for services received outside the HMO network except under very specific circumstances (for example, life-threatening emergencies).

There are different kinds of HMOs. Some have all their doctors located in facilities owned by the HMO. Some are networks of physicians who maintain their own offices and service HMO patients as a part of their regular practice.

HMO plans and premiums vary. A "low option" HMO plan generally covers at least the services included under the regular Medicare program. A "high option" plan usually includes additional services not covered by Medicare, for example, eye care.

For further information on Medicare-contracting HMOs, write the New Jersey Department of Insurance, Enforcement and Consumer Protection, Senior Health Insurance Program, CN 325, Trenton, NJ 08625.

Medicare Supplement Policies

If you are looking for a policy specifically designed to coordinate with Medicare, you may want to consider a Medicare supplement policy. The phrase "Medicare supplement" is a special term reserved in New Jersey for policies that meet minimum standards set by the state. You must have both Parts A and B of Medicare to purchase this kind of policy.

Because people who want to purchase health insurance coverage to supplement Medicare come from varying backgrounds, there is no one "best" policy for everyone. You should first decide what you can afford, and what your individual needs and wants are in the way of insurance benefits before you purchase coverage.

For example, someone who can only afford to pay $50 per month for a policy has already eliminated any plan that costs over that each month and will need to choose from those plans available in his or her price range.

Also, just because an individual can afford a $100 per month policy does not mean he or she should not consider a less expensive policy. If the more expensive plan contains one or more benefits the person does not want, (for example, Care Outside the United States and At–Home Recovery) then a less expensive plan without these benefits may be a better buy.

Until recently, there were hundreds of Medicare supplement policies being sold throughout the country. The benefits provided by these policies varied greatly, which created much confusion on the part of consumers. In 1990, however, the federal government, under the Omnibus Budget Reconciliation Act (OBRA) '90 law, made a move to reduce the number of Medicare supplement policies being sold. As a result, 10 policy designs were approved. This makes it easier for a consumer to compare Medicare supplement policies. These 10 plans are labelled "A" through "J".

Plan A is known as the "Core" plan, and all of its benefits are found in each of the other nine plans ("B" through "J") as well.

The Core plan's benefits pay for:

—Part A co-payments: days 61–90 in a hospital; days 91–150 in a hospital;

—100% of hospital expenses after 150 days (when Medicare runs out), up to a total of 365 days in a lifetime;

—Part B co-payments: 20% of Medicare's approved amount; and

—Costs for the first three pints of blood each year.

In addition to the Core plan benefits, plans B through J include various other benefits, such as coverage for the Part B deductible, prescription drugs and preventive health care.

The 10 Medicare supplement policy designs, A through J, are shown in the following chart:

TEN STANDARD MEDICARE SUPPLEMENT PLANS

BASIC BENEFITS (Included in All Plans)
HOSPITALIZATION: Part A Coinsurance Plus Coverage for 365 Additional Days in a Lifetime After Medicare Benefits End
MEDICAL EXPENSES: Part B Coinsurance (20% of Medicare-Approved Expenses)
BLOOD: Cost of First Three Pints of Blood Each Year

A	B	C	D	E	F	G	H	I	J
BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	BASIC BENEFITS	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 (80%)		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 PER YEAR LIMIT)	BASIC DRUGS ($1,250 PER YEAR LIMIT)	EXTENDED DRUGS ($3,000 PER YEAR LIMIT)
				PREVENTIVE CARE					PREVENTIVE CARE

New Jersey law allows all 10 plan designs to be sold in the state. Consumers, however, may not find all 10 plan designs available to them because insurance companies selling Medicare supplement policies have the option to sell which plans they choose. If an insurance company does choose to sell one or more Medicare supplement policies, the Core plan must be one of these plans.

The Department of Insurance maintains a list of the individual Medicare supplement polices for sale in New Jersey. If you need a copy of the list, send a self-addressed,

stamped envelope to the Department of Insurance, Enforcement and Consumer Protection, Senior Health Insurance Program, CN 325, Trenton, New Jersey 08625.

Limited Benefit Policies

Policies that do not pay all the benefits or do not pay the dollar amounts of the benefits that are required of Medicare supplement policies are called "limited benefit" policies.

These plans can provide some limited coverage when added to your Medicare insurance. However, the coverage provided is not considered adequate to fill gaps in Medicare.

Limited benefit policies that are designed to be added to your Medicare coverage may be called by different names, which may be confusing to an uninformed consumer. These plans may be referred to as "complements" or "supplemental" policies—different than Medicare supplement policies.

Also, a consumer may be confused by advertising literature. The consumer may believe that the policy adequately covers the gaps in Medicare; however, coverage is generally limited to in-hospital services.

With some policies, both inpatient and outpatient coverage may be available, but benefits are usually limited to eligible services and/or limited amounts payable per calendar year.

These policies are often less costly than most Medicare supplement policies and therefore may be attractive to persons on Medicare looking to purchase additional insurance coverage. If you can afford a Medicare supplement policy, there is no need to have a "limited benefit" policy.

Examples of limited benefit policies are discussed below.

Blue Cross and Blue Shield Coverage

Blue Cross and Blue Shield of New Jersey, Inc., a nonprofit health service corporation, has offered plans designed to complement Medicare, in addition to Super 65, a Medicare supplement policy. These are:

"65"—Blue Cross and Blue Shield 65 is designed to provide basic hospitalization coverage. It pays the Part A deductible and co-payments, and costs for care outside the United States. It also pays the Part B deductible and 20 percent of Medicare's approved amount for doctors who treat you while you are hospitalized. Blue Cross and Blue Shield 65 pays 20 percent co-payments for some services outside a hospital but there are annual dollar maximums. It does not pay for hospitalization after 150 days (when Medicare runs out) and it does not cover physician home or office visits.

"65 Select"—Blue Cross and Blue Shield 65 Select is primarily aimed at covering the costs for a long hospital stay. You pay the everyday health care costs—the Part A and B deductibles and some medical co-payments—yourself. 65 Select pays the Part A hospitalization co-payments, the Part B co-payment for physician care in the hospital, and 90 percent of hospital costs after Medicare runs out. It pays for some services performed outside a hospital, subject to annual dollar maximums, and for health care costs while traveling outside the United States. 65 Select does not cover physician home or office visits.

Hospital Indemnity Policies

Frequently advertised by celebrities, indemnity policies pay a fixed amount of money per day, week or month while you are in the hospital. They are not designed, however, to fill Medicare's gaps. Therefore, you should not buy a hospital indemnity policy as your only additional health coverage to supplement Medicare.

The advantages are that they pay you regardless of whether you have other hospital coverage, and the money is yours to spend as you see fit.

The disadvantage is that they pay only if you are hospitalized. No matter what your medical bills are, you cannot collect unless you are in the hospital. And, depending on the policy you choose, you may not collect much even then. Under New Jersey's minimum standards, the laws which set out the basic benefits that policies must provide, hospital indemnity policies must begin paying by day four of your hospital stay. But they do not have to pay before the fourth day. Therefore, if you leave the hospital after day three, they may not pay you anything. In addition, some policies stop paying after 31 days.

You should also be aware of the fact that the payments made to you may be much lower than your bills (even though individual policies sold in New Jersey are required to pay at least $40 a day). Moreover, the amount of the benefits can remain the same year after year, so, unless you update your coverage occasionally, inflation will take its toll on the value of the payments. (That is, the medical costs will increase, but your benefits will not.) Therefore, if you do buy a hospital indemnity policy, try to update it every few years.

Accident–Only Policies

These policies provide coverage for death, dismemberment, disability or hospital and medical care due to an accident. They are not designed to pay routine health care costs. Since Medicare pays regardless of whether the reason for medical attention is an illness or an accident, it is very likely that having one of these policies is a duplication of benefits you already have.

Therefore, do not buy an accident-only policy as your only additional health coverage to supplement Medicare.

Specified Disease Policies

You may have received advertisements in the mail for "dread-disease policies"—policies that will cover you for specific diseases, like cancer. They are such a bad buy that they are banned for sale in New Jersey, but may still be available to some consumers as members of an organization headquartered outside the state.

Specified disease policies are a bad buy because they pay in so few situations that odds are heavily stacked in favor of the company never having to pay you anything.

As with accident-only policies, it is very likely that a specified disease policy duplicates benefits which are ordinarily covered under Medicare. Since specified disease policies generally pay only for services related to the specific disease for which they have been designed, you would have more comprehensive coverage with Medicare and a Medicare supplement policy.

Long Term Care Policies

Long-term care refers to a wide range of medical and non-medical services people need for a long period of time due to a chronic illness, disability, or physical or mental handicap. Long-term care can be provided in a nursing home, at home or in a community facility, such as an adult day care center.

Long-term care insurance policies cover different levels of nursing home care—skilled, intermediate and custodial. Some will also help pay for alternatives to nursing home care; for example, home care and adult day care.

Before you buy a long-term care policy, be sure to read the policy provisions carefully. For example, check to see whether the policy pays benefits for skilled, intermediate and custodial nursing home care; whether it covers home health care services; what its definition is for each level of care; whether there is a waiting period (a period of time you have to be in the nursing home or receive home care before the policy will pay benefits); whether the policy specifically excludes coverage for any conditions; how long the policy will pay benefits; and, under what conditions the company can cancel or refuse to renew the policy.

Long-term care insurance is generally purchased to fill some additional gaps in Medicare which are not filled by your other supplement coverage. It should be purchased only after you have adequate supplement coverage under another type of health insurance plan.

For a copy of our "Buyer's Guide to Long–Term Care Insurance", send a self-addressed legal size envelope to: Long Term Care Buyer's Guide, Public Affairs Division, Department of Insurance, CN 325, Trenton, New Jersey 08625.

AUTO INSURANCE PERSONAL INJURY PROTECTION (PIP)

Most New Jersey residents now have the option of selecting their health coverage provider, rather than their auto insurance company, to pay for their no-fault medical expense claims.

Medicare and Medicaid will NOT provide primary coverage. If your primary health benefits are provided by either Medicare or Medicaid, you cannot choose this option. Medicare will consider payment of claims only after you have submitted them to the primary carrier(s).

BE AN EDUCATED CONSUMER

Now that you know what Medicare does not cover, and what kinds of coverages are available, you are ready to set your strategy.

If you are concerned about day-to-day expenses, look for a policy that provides coverage in as many situations as possible. Generally speaking, it is better to buy a Medicare supplement policy which covers a broad spectrum of medical expenses than a hospital indemnity policy which pays you only a small amount for days you spend in the hospital, but nothing toward your actual hospital or medical bills.

Do Not Duplicate Coverage

It is a federal crime for someone to knowingly sell you a policy that duplicates Medicare or any private health policy you already have.

If you already are covered under more than one health policy, you should review these for duplication of benefits. It is better to have the most comprehensive policy you can afford than several policies that duplicate coverage. Some policies will not pay for an expense already covered under another policy. So if you have two of the same kind of policy, you can wind up with two sets of payments but only one set of benefits.

Watch Out for Key Phrases

Policies are contracts, and like other legal documents, they use special vocabulary, including:

Preexisting Condition Exclusions. Policies may not pay bills for a health condition you had before you bought the policy. This usually is not a problem with coverage extended by employers, and in New Jersey, Medicare supplement policies must pay for any conditions after you have had the policy for six months. But policies that are not called Medicare supplement policies, such as hospital indemnity policies, can have pre-existing condition waiting periods of up to two years.

Maximums. A policy may have a maximum dollar amount that it will pay under the entire policy, a maximum it will pay within a given period of time or a limit on what it will pay for specific treatments. Hospital indemnity policies, for instance, may pay a specific amount per day, $40 for example, up to a maximum amount per month.

Renewal. Find out if and when a company can refuse to renew the policy. There are three common types of renewal conditions:

Guaranteed renewable. This means that the company agrees to renew each year until you reach a certain age or for life as long as you pay the premium.

You may see policies that are:

Conditionally renewable. This means that the company agrees to renew as long as the company continues to insure people in the state with the same kind of policy. If the company decides to discontinue selling that kind of policy here, the coverage can be non-renewed at the end of the policy year or the next premium due date.

Renewable at company option. A policy with this provision can be non-renewed for any reason at the end of the policy year. This kind of clause is prohibited in New Jersey for individual policies, but you may see sales materials for policies with this type of renewal clause from groups outside the state.

A Word of Caution

Do not be fooled into thinking that a company or agent represents Medicare or any other federal or state sponsored insurance program. The New Jersey Department of Insurance sets minimum standards for policies and companies, but it does not endorse or sell policies.

Do not be pressured or frightened into buying something you may not ever be able to use, like a cancer policy. If the literature you have does not discuss the important items mentioned here, ask for an Outline of Coverage.

Be honest on the insurance application. If you lie or do not give a complete medical history, the company can refuse to pay. If someone else helps you fill out the application, check it before signing. It is your claim that will be denied if incorrect medical history is on the application.

Do not pay in cash. Use a check, money order or bank draft and be sure it is payable to the company, not the agent or anyone else. Remember, even a guaranteed renewable policy can be cancelled if you do not pay your premium, so you want a record of your payments.

Some Final Notes

By law, depending on the type of insurance policy you are considering, you may have a 10 to 30–day "free-look" period in which to review the policy and return it for a full refund if you are not satisfied. (Medicare Supplement and Long-term care policies have a 30–day free look period.)

If you do not receive the policy within 30 days after applying, contact the company and obtain in writing a reason for the delay. If 60 days go by without information, you can write the Department of Insurance, Enforcement and Consumer Protection, CN 325, Trenton, NJ 08625; or, call (609) 292–5360.

It is a violation of state regulations for your doctor to charge you a fee for filling out your claim form. If your doctor does charge you, you can file a complaint with the State Board of Medical Examiners, 28 W. State Street, Room 602, Trenton, NJ 08608.

Claim payments should be mailed promptly. If you experience delays, do not be afraid to assert your rights. Insurance companies sometimes make mistakes; your inquiry or complaint may help to bring a faster or fairer claim settlement.

Getting Help

To get help filling out claim forms, evaluating policies and finding answers to your health insurance questions, you can contact the Senior Health Insurance Program (SHIP). SHIP is a free service designed to help you with your health insurance problems or questions. You can contact the New Jersey Division on Aging at 1–800–792–8820 for the number of the SHIP office in your county.

If you need other help, write the Department of Insurance, Enforcement and Consumer Protection, Senior Health Insurance Program, CN–325, Trenton, New Jersey 08625.

EXHIBIT B
MEDICARE DEDUCTIBLES AND CO-PAYMENTS FOR 1992

Medicare Part A Service	**Length of Stay**	**You Pay**	**Medicare Pays**
Hospitalization	First 60 days	$652 deductible	Balance
	61st-90th day	$163 co-payment per day	Balance
	91st-150th day	$326 co-payment per day	Balance
	Beyond 150 days	All costs	Nothing
Post-hospital Skilled Nursing Facility Care	First 20 days	Nothing *provided all conditions are met (see Your Medicare Handbook)	All Costs
	21st-100th day	$81.50 co-payment per day	Balance
Home Health Care		Nothing *provided all conditions are met (see Your Medicare Handbook)	All Costs
Hospice Care *Nursing care, physician's services, physical/occupational therapy, medical supplies, home health aide services, counseling services (except for bereavement counseling).		Nothing *provided all conditions are met (see Your Medicare Handbook)	All Costs
*Drugs and Biologicals		5% co-payment	Balance
*Respite Care		5% co-payment	Balance
Medicare Part B Medical Expenses		$100 annual deductible 20% of Medicare-approved amount after deductible	80% of Medicare-approved amount after deductible

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**
MEDICARE PART A SERVICES AND SUPPLIES				
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 of 1st 20 days (after a 3 day prior hospital confinement) benefit period	
		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	
		All but $_____ a day for 21st-100th days/benefit period		
		Beyond 100 days—Nothing/benefit period	Beyond 100 days—Nothing/benefit period	
MEDICARE PART B SERVICES AND SUPPLIES		80% of allowable charges (after $_____ deductible)	80% of allowable charges (after $_____ deductible/ calendar year)	
PRESCRIPTION DRUGS		Inpatient prescription drugs. 80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant (after $_____ deductible/calendar year)	Inpatient prescription drugs. 80% of allowable charges for immuno-suppressive 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. 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).

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

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	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 (80%)		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)	Extended Drugs ($3,000 Limit)
				Preventive Care					Preventive Care

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$0	$628 (Part A Deductible)
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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
SKILLED NURSING FACILITY CARE*			
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 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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
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,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
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
CLINICAL LABORATORY SERVICES—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 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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
SKILLED NURSING FACILITY CARE* 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 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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
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,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
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
CLINICAL LABORATORY SERVICES—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 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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
SKILLED NURSING FACILITY CARE* 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 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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
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,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
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
CLINICAL LABORATORY SERVICES—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	PLAN PAYS	YOU PAY
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 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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
SKILLED NURSING FACILITY CARE*			
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 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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
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,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
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
CLINICAL LABORATORY SERVICES—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 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
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 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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
SKILLED NURSING FACILITY CARE*			
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 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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
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,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
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
CLINICAL LABORATORY SERVICES—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 Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria 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

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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
SKILLED NURSING FACILITY CARE*			
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 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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
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,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
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
CLINICAL LABORATORY SERVICES—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	PLAN PAYS	YOU PAY
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 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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
SKILLED NURSING FACILITY CARE* 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 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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
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,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
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
CLINICAL LABORATORY SERVICES—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 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
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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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
SKILLED NURSING FACILITY CARE*			
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 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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
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,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
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
CLINICAL LABORATORY SERVICES—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 Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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
SKILLED NURSING FACILITY CARE* 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 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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
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,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
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
CLINICAL LABORATORY SERVICES—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 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
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
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
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

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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
SKILLED NURSING FACILITY CARE*			
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 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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
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,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
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
CLINICAL LABORATORY SERVICES—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 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
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
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
PREVENTIVE MEDICARE CARE BENEFIT—NOT COVERED BY MEDICARE			
Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, 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	PLAN PAYS	YOU PAY
(Description of benefit) (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)

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. Terminate your present coverage only if, after due consideration, you find that purchase of this coverage is a wise decision.

STATEMENT TO APPLICANT BY CARRIER, AGENT (BROKER OR OTHER REPRESENTATIVE):

I (We) have reviewed your current medical or health coverage. The replacement involved in this transaction does not duplicate coverage, to the best of my (our) knowledge. 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 (___) _____

Line		(a) Earned Premium (x)	(b) Incurred Claims (y)
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: Total Actual Incurred Claim (line 3, col. b) / Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6) = 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

Ratio 3 = Ratio 2 + 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.

(w) "SMSBP" = Standardized Medicare Supplement Benefit Plan

(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 _____ 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		0.507		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)

(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.

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

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.