

CHAPTER 4
ACTUARIAL SERVICES

Authority

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

Source and Effective Date

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

Executive Order No. 66(1978) Expiration Date

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

Chapter Historical Note

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

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

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

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

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

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

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

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

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

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

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

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

Subchapter 2, Replacement of Life Insurance Policy, was repealed and Subchapter 2, Replacement of Life Insurance Policy, was adopted as new rules by R.1982 d.16, effective February 1, 1982, operative June 1, 1982.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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Source and Effective Date

R.2001 d.122, effective April 2, 2001.
See: 32 N.J.R. 3907(a), 33 N.J.R. 1109(a).

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SUBCHAPTER 1. NEW JERSEY INSOLVENT HEALTH MAINTENANCE ORGANIZATION ASSISTANCE ASSOCIATION

Authority

N.J.S.A. 17:1-8.1; 17:1-15e; and 17B:32B-1 et seq.

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Rewrote the section.

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.

“Annuity 2000 Mortality Table” means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research and shown on page 240 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

“NAIC” means the National Association of Insurance Commissioners.

“1983 Table ‘a’” means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners (see *1982 Proceedings of the NAIC II*, page 454).

“1983 GAM Table” means that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners (see *1984 Proceedings of the NAIC I*, pages 414 to 415).

“1994 GAR Table” means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and shown on pages 866-867 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Rewrote the section.

11:4-26.3 Individual annuity or pure endowment contracts

(a) Except as provided in (b) and (c) below, the 1983 Table “a” is recognized and 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 annuity or pure endowment contract issued on or after September 11, 1981.

(b) Except as provided in (c) below, either the 1983 Table “a” or the Annuity 2000 Mortality Table 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.

(c) Except as provided in (d) below, the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2001.

(d) The 1983 Table “a” without projection is to be used for determining the minimum standard of valuation for an individual annuity or pure endowment contract issued on or after January 1, 2001, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

1. Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;
2. Settlements involving similar actions such as worker’s compensation claims; or
3. Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Rewrote the section.

11:4-26.4 Group annuity or pure endowment contracts

(a) Except as provided in (b) and (c) below, the 1983 GAM Table, the 1983 Table “a” and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one of these tables 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) Except as provided in (c) below, either the 1983 GAM Table or the 1994 GAR 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.

(c) The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 2001 under a group annuity or pure endowment contract.

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Rewrote the section.

11:4-26.5 Application of the 1994 GAR Table

(a) In using the 1994 GAR Table, the mortality rate for a person age x in year $(1994+n)$ is calculated as follows:

$$q_x^{1994+n} = q_x^{1994} (1 - AA_x)^n$$

where the q_x^{1994} and AA_x s are as specified in the 1994 GAR Table.

New Rule, R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

Former N.J.A.C. 11:4-26.5, Separability, recodified to N.J.A.C. 11:4-26.6.

11:4-26.6 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.

Recodified from N.J.A.C. 11:4-26.5 by R.2001 d.7, effective January 2, 2001.

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

SUBCHAPTER 27. (RESERVED)

SUBCHAPTER 28. GROUP COORDINATION OF BENEFITS
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.

Case Notes

Medical plan’s coordination of benefits provision, which stated that if dependent was employee under another plan which attempted to provide only reimbursement coverage, first plan would not provide any coverage at all was unenforceable escape clause under Employee Retirement Income Security Act (ERISA). *McGurl v. Trucking Employees of North Jersey Welfare Fund, Inc.*, 124 F.3d 471 (C.A.3 1997).

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

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: