

“Department” means the New Jersey Department of Banking and 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 and which provides a death benefit greater than premiums accumulated at the nonforfeiture interest rate used to determine nonforfeiture values under the policy during the limited death benefit period defined at N.J.A.C. 11:4-21.3(g).

“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. Limited death benefit policies include those single pay and limited pay life insurance policy forms where, at any issue age, the premium or premiums accumulated at the nonforfeiture interest rate used to determine nonforfeiture values under the policy are equal to or in excess of the guaranteed death benefit during the limited death benefit period defined at N.J.A.C. 11:4-21.3(g), regardless of whether the form is underwritten. Limited death benefit policies also include those funeral insurance policies as defined at N.J.S.A. 17B:17-5.1a that meet the requirements set forth in N.J.A.C. 11:4-21.1(b).

Amended by R.1996 d.82, effective February 20, 1996.
See: 27 N.J.R. 3716(a), 28 N.J.R. 1213(a).

Amended “Full death benefit policy” and “Limited death benefit policy”.

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

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

Amended by R.2006 d.132, effective April 17, 2006.

See: 37 N.J.R. 4859(a), 38 N.J.R. 1743(a).

In definition of “advertising,” substituted “producer” for “agent” throughout.

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 producers, 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 policy shall include a provision allowing for the return of the policy for a full refund of premiums within 30 days after delivery.

Amended by R.1996 d.82, effective February 20, 1996.

See: 27 N.J.R. 3716(a), 28 N.J.R. 1213(a).

Eliminated amount and issue age limitations.

Amended by R.2006 d.132, effective April 17, 2006.

See: 37 N.J.R. 4859(a), 38 N.J.R. 1743(a).

In (e), substituted “producers” for “agents”.

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

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.

"Non-Norris market" means all employer-based plans not included within the definition of "Norris market" set forth in this subchapter.

"Norris market" means all employer-based plans subject to the holding of the 1983 Arizona Governing Committee v. Norris United States Supreme Court decision (463 U.S. 1073).

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".

Amended by R.1996 d.148, effective March 18, 1996.
See: 27 N.J.R. 3717(a), 28 N.J.R. 1545(a).

Added "Norris market" and "Non-Norris market".

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 (a)1 above 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 subchapter:

1. 100 percent Male 0 percent Female for tables to be designated as the "1980 CSO-A" and "1980 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;

SUBCHAPTER 27A. PREFERRED MORTALITY
TABLES FOR USE IN DETERMINING MINIMUM
RESERVE LIABILITIES

11:4-27A.1 Purpose and scope

(a) The purpose of this subchapter is to recognize, permit and prescribe the use of mortality tables that reflect differences in mortality between Preferred and Standard lives in determining minimum reserve liabilities in accordance with N.J.S.A. 17B:19-8, N.J.A.C. 11:4-27 and N.J.A.C. 11:4-32.

(b) This subchapter applies to all annual valuations of reserves for calendar years beginning on or after January 1, 2007.

11:4-27A.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 Banking and Insurance.

“Department” means the New Jersey Department of Banking and Insurance.

“2001 CSO Mortality Table” means that mortality table adopted for use at N.J.A.C. 11:4-27 consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002) and supplemented by the 2001 CSO Preferred Class Structure Mortality Table defined below. Unless the context indicates otherwise, the 2001 CSO Mortality Table includes both the ultimate form of that table and the select and ultimate form of that table. It also includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables. Mortality tables in the 2001 CSO Mortality Table include the following:

1. “2001 CSO Mortality Table (F)” means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table;
2. “2001 CSO Mortality Table (M)” means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table;
3. “Smoking-Status-Composite mortality tables” means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers; and
4. “Smoker and nonsmoker mortality tables” means mortality tables with separate rates of mortality for smokers and nonsmokers.

“2001 CSO Preferred Class Structure Mortality Table” means mortality tables with separate rates of mortality for Super Preferred Nonsmokers, Preferred Nonsmokers, Residual Standard Nonsmokers, Preferred Smokers, and Residual Standard Smoker splits of the 2001 CSO Nonsmoker and Smoker tables as adopted by the NAIC at the September, 2006 national meeting and published in the Proceedings of the NAIC (3rd Quarter 2006), incorporated herein by reference. See www.naic.org and www.soa.org/research/individual-life/intl-2001-cso-preferred-class-structure-mortality-tables.aspx. Unless the context indicates otherwise, the “2001 CSO Preferred Class Structure Mortality Table” includes both the ultimate form of that table and the select and ultimate form of that table. It also includes both the smoker and nonsmoker mortality tables. It includes both the male and female mortality tables and the gender composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality table.

**11:4-27A.3 2001 CSO Preferred Class Structure
Mortality Table**

(a) At the election of the insurer, for each calendar year of issue, for any one or more specified plans of insurance and subject to satisfying the conditions stated in this subchapter, the 2001 CSO Preferred Class Structure Mortality Table may be substituted in place of the 2001 CSO Smoker or Nonsmoker Mortality Table as the minimum valuation standard for policies issued on or after January 1, 2007. The 2001 CSO Preferred Class Structure Mortality Table is available on the NAIC’s website at www.soa.org/research/individual-life/intl-2001-cso-preferred-class-structure-mortality-tables.aspx. The Department shall notify insurers of any changes to the 2001 CSO Preferred Class Structure Mortality Table by Bulletin.

(b) No such election as described in (a) above shall be made until the insurer demonstrates to the Commissioner that at least 20 percent of the business to be valued on this table is in one or more of the preferred classes. A table from the 2001 CSO Preferred Class Structure Mortality Table used in place of a 2001 CSO Mortality Table, pursuant to the requirements of this subchapter, shall be treated as part of the 2001 CSO Mortality Table only for purposes of reserve valuation pursuant to the requirements of N.J.A.C. 11:4-27.

(c) If an insurer elects to use the 2001 CSO Preferred Class Structure Mortality Table for a plan of insurance in a particular calendar year of issue, the insurer shall use this table for that plan of insurance in all future calendar years of issue unless discontinuance is approved pursuant to rules promulgated by the Commissioner.

11:4-27A.4 Conditions

(a) For each plan of insurance with separate rates for Preferred and Standard Nonsmoker lives, an insurer may use the Super Preferred Nonsmoker, Preferred Nonsmoker, and Residual Standard Nonsmoker tables to substitute for the Nonsmoker mortality table found in the 2001 CSO Mortality

Table to determine minimum reserves. At the time of election and annually thereafter, except for business valued under the Residual Standard Nonsmoker Table, the appointed actuary shall certify that:

1. The present value of death benefits over the next 10 years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class; and

2. The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(b) For each plan of insurance with separate rates for Preferred and Standard Smoker lives, an insurer may use the Preferred Smoker and Residual Standard Smoker tables to substitute for the Smoker mortality table found in the 2001 CSO Mortality Table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the Preferred Smoker Table, the appointed actuary shall certify that:

1. The present value of death benefits over the next 10 years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the Preferred Smoker valuation basic table corresponding to the valuation table being used for that class; and

2. The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the Preferred Smoker valuation basic table.

(c) Unless the Commissioner finds that the use of it will have no material financial impact on the insurer, every authorized insurer using the 2001 CSO Preferred Class Structure Table shall annually file with the Commissioner statistical reports showing mortality and such other information as the Commissioner may specify as necessary for the administration of the provisions of this subchapter (that is, information related to a mortality study, including exposed lives and amounts of insurance, policy size, type of product, age and gender, underwriting criteria used to determine preferred mortality, and the number of people applying and rejected for preferred underwriting). The form of the reports shall be established by the Commissioner. The Commissioner shall annually post on the Department's website the instructions for and format of this report, specifying the information

to be provided in the report and identifying the party with whom the report is to be filed and the address where the filing is to be made.

11:4-27A.5 Separability

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

11:4-27A.6 Effective date

This subchapter shall become effective on March 17, 2008.

SUBCHAPTER 28. GROUP COORDINATION OF BENEFITS

11:4-28.1 Purpose and scope

(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, delivered or renewed in New Jersey by insurers transacting the business of health insurance, health service corporations, hospital service corporations, medical service corporations, dental service corporations, dental plan organizations, health maintenance organizations and all similar organizations.

Amended by R.2002 d.106, effective April 1, 2002 (operative January 1, 2003).

See: 33 N.J.R. 2578(a), 34 N.J.R. 1440(a).

Rewrote (b).

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 charge for any health care service, supply or other item of expense for which the covered person is liable, when the health care service, supply or item of expense is covered at least in part under any of the plans involved, except where a statute requires a different definition, or as otherwise specified in this subchapter.

1. A plan's COB provision may exclude from allowable expenses items of expense arising under coverages such as dental care, vision care, prescription drug or hearing aid programs. When a plan provides benefits only for dental care, vision care, prescription drugs or hearing aids, the COB provision of the group contract may limit allowable expenses to like items of expense.

2. 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.

3. When a plan restricts COB to specific coverage in a contract (for example, major medical or dental), the group contract shall consider only the corresponding expenses or services to which COB applies as allowable expense.

"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.

1. The Ten Year Select Mortality Factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

2. The select factors in the subchapter Appendix, incorporated herein by reference; or

3. Any other table of select mortality factors adopted by the NAIC after January 1, 2000 and promulgated by regulation by the Commissioner for the purpose of calculating basic reserves.

(b) Deficiency reserves, if any, are calculated for each policy as the excess, if greater than zero, of the quantity A over the basic reserve. The quantity A is obtained by recalculating the basic reserve for the policy using guaranteed gross premiums instead of net premiums when the guaranteed gross premiums are less than the corresponding net premiums. At the election of the insurer for any one or more specified plans of insurance, the quantity A and the corresponding net premiums used in the determination of quantity A may be based upon the 1980 CSO valuation tables with select mortality factors (or any other valuation mortality table adopted by the NAIC after January 1, 2000 and promulgated by the Commissioner). If select mortality factors are elected, they may be:

1. The Ten Year Select Mortality Factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law;

2. The select mortality factors in the Appendix to this subchapter; or

3. For durations in the first segment, X percent of the select mortality factors in the Appendix, subject to the following:

i. X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience;

ii. X shall not be less than 20 percent;

iii. X shall not decrease in any successive policy years;

iv. X is such that, when using the valuation interest rate used for basic reserves, item (1) below is greater than or equal to item (2) below:

(1) The actuarial present value of future death benefits, calculated using the mortality rates resulting from the application of X;

(2) The actuarial present value of future death benefits calculated using anticipated mortality experience without recognition of mortality improvement beyond the valuation date;

v. X is such that the mortality rates resulting from the application of X are at least as great as the anticipated mortality experience, without recognition of

mortality improvement beyond the valuation date, in each of the first five years after the valuation date;

vi. The appointed actuary shall increase X at any valuation date where it is necessary to continue to meet all the requirements of this paragraph and (b)4 below;

vii. The appointed actuary may decrease X at any valuation date as long as X does not decrease in any successive policy years and as long as it continues to meet all the requirements of this paragraph and (b)4 below;

viii. The appointed actuary shall specifically take into account the adverse effect on expected mortality and lapsation of any anticipated or actual increase in gross premiums.

4. If X in (b)3 above is less than 100 percent at any duration for any policy, the following requirements shall be met:

i. The appointed actuary shall annually prepare an actuarial opinion and memorandum for the insurer in conformance with the requirements of N.J.A.C. 11:1-21A.6; and

ii. The appointed actuary shall annually opine for all policies subject to this subchapter as to whether the mortality rates resulting from the application of X meet the requirements of (b)3 and 4. This opinion shall be supported by an actuarial report, subject to appropriate actuarial standards of practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries. The X factors shall reflect anticipated future mortality, without recognition of mortality improvement beyond the valuation date, taking into account relevant emerging experience.

5. Any other table of select mortality factors adopted by the NAIC after January 1, 2000 and promulgated by the Commissioner for the purpose of calculating deficiency reserves.

(c) This subsection applies to both basic reserves and deficiency reserves. Any set of select mortality factors may be used only for the first segment. However, if the first segment is less than 10 years, the appropriate Ten Year Select Mortality Factors incorporated into the 1980 amendments to the NAIC Standard Valuation Law may be used thereafter through the 10th policy year from the date of issue.

(d) In determining basic reserves or deficiency reserves, guaranteed gross premiums without policy fees may be used where the calculation involves the guaranteed gross premium but only if the policy fee is a level dollar amount after the first policy year. In determining deficiency reserves, policy fees may be included in guaranteed gross premiums, even if not included in the actual calculation of basic reserves.

(e) Reserves for policies that have changes to guaranteed gross premiums, guaranteed benefits, guaranteed charges, or guaranteed credits that are unilaterally made by the insurer after issue and that are effective for more than one year after the date of the change shall be the greatest of the following:

1. Reserves calculated ignoring the guarantee;
2. Reserves assuming the guarantee was made at issue; and
3. Reserves assuming that the policy was issued on the date of the guarantee.

(f) The Commissioner may require that the insurer document the extent of the adequacy of reserves for specified blocks, including but not limited to policies issued prior to January 1, 2000. This documentation may include a demonstration of the extent to which aggregation with other non-specified blocks of business is relied upon in the formation of the appointed actuary opinion pursuant to and consistent with the requirements of N.J.S.A. 17B:19-10 and N.J.A.C. 11:1-21A.

Administrative correction.
See: 32 N.J.R. 477(a).

11:4-32.4 Calculation of minimum valuation standard for policies with guaranteed non-level gross premiums or guaranteed non-level benefits (other than universal life policies)

(a) Basic reserves shall be calculated as the greater of the segmented reserves and the unitary reserves. Both the segmented reserves and the unitary reserves for any policy shall use the same valuation mortality table and selection factors. At the option of the insurer, in calculating segmented reserves and net premiums, either of the adjustments described in (a)1 or 2 below may be made:

1. Treat the unitary reserve, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the unitary reserve, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.
2. Treat the guaranteed cash surrender value, if greater than zero, applicable at the end of each segment as a pure endowment; and subtract the guaranteed cash surrender value, if greater than zero, applicable at the beginning of each segment from the present value of guaranteed life insurance and endowment benefits for each segment.

(b) Deficiency reserves shall be subject to the following rules:

1. Deficiency reserves at any duration shall be calculated in the following manner:

- i. On a unitary basis if the corresponding basic reserve determined by (a) above is unitary;
- ii. On a segmented basis if the corresponding basic reserve determined by (a) above is segmented; or
- iii. On the segmented basis if the corresponding basic reserve determined by (a) above is equal to both the segmented reserve and the unitary reserve.

2. This subsection shall apply to any policy for which the guaranteed gross premium at any duration is less than the corresponding modified net premium calculated by the method used in determining the basic reserves, but using the minimum valuation standards of mortality (specified at N.J.A.C. 11:4-32.3(b)) and rate of interest.

3. Deficiency reserves, if any, shall be calculated for each policy as the excess if greater than zero, for the current and all remaining periods, of the quantity A over the basic reserve, where A is obtained as indicated at N.J.A.C. 11:4-32.3(b).

4. For deficiency reserves determined on a segmented basis, the quantity A is determined using segment lengths equal to those determined for segmented basic reserves.

(c) Basic reserves may not be less than the tabular cost of insurance for the balance of the policy year, if mean reserves are used. Basic reserves may not be less than the tabular cost of insurance for the balance of the current modal period or to the paid-to-date, if later, but not beyond the next policy anniversary, if mid-terminal reserves are used. The tabular cost of insurance shall use the same valuation mortality table and interest rates as that used for the calculation of the segmented reserves. However, if select mortality factors are used, they shall be the Ten-Year Select Mortality Factors incorporated into the 1980 amendments of the NAIC Standard Valuation Law. In no case may total reserves (including basic reserves, deficiency reserves and any reserves held for supplemental benefits that would expire upon contract termination) be less than the amount that the policyowner would receive (including the cash surrender value of the supplemental benefits, if any, referred to above), exclusive of any deduction for policy loans, upon termination of the policy.

(d) The following apply to unusual patterns of guaranteed cash surrender values:

1. For any policy with an unusual pattern of guaranteed cash surrender values, the reserves actually held prior to the first unusual guaranteed cash surrender value shall not be less than the reserves calculated by treating the first unusual guaranteed cash surrender value as a pure endowment and treating the policy as an n year policy providing term insurance plus a pure endowment equal to the unusual cash surrender value, where n is the number of years from the date of issue to the date the unusual cash surrender value is scheduled.