

8. The first page of every policy shall contain, in at least 14 point type but not less than the size of type used for policy captions, and in capital letters, a prominent statement, as follows: "THIS IS A LIMITED POLICY (OR CERTIFICATE). IT PAYS BENEFITS FOR (NAME OF SPECIFIED DISEASES) ONLY AND DOES NOT PROVIDE COVERAGE FOR ANY OTHER MEDICAL CONDITIONS. YOU SHOULD MAINTAIN SEPARATE COMPREHENSIVE HEALTH COVERAGE. READ THIS POLICY CAREFULLY WITH THE OUTLINE OF COVERAGE."

9. Application forms shall include a question to determine whether the applicant has other coverage providing benefits for hospital and medical services and supplies. If the applicant does not respond affirmatively to such question, the policy shall not be issued.

10. Every policy shall be issued only to persons who are covered by insurance that provides benefits for hospital and medical services and supplies.

11. No policy shall provide for a reduction of benefits upon attainment of any age or other condition, or upon the occurrence of any event(s).

12. No policy shall provide for a probationary or waiting period during which no coverage is provided under the policy.

13. Every policy 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 within 30 days of its delivery and to have the premium or subscription charge or fees refunded if, after examination of the policy, the insured is not satisfied for any reason.

11:4-53.4 Standards for specified disease coverage

(a) Specified disease policies shall provide the following minimum benefits:

1. A fixed-sum benefit of at least \$100.00 for each day of hospital confinement for at least 365 days; and

2. A fixed-sum benefit equal to at least one-half of the benefit for hospital confinement, for each day of hospital or non-hospital outpatient surgery or other medically appropriate outpatient treatment, including but not limited to chemotherapy and radiation therapy, for at least 365 days.

(b) Benefits for confinement in a skilled nursing home or for home health care are optional. If a policy provides these benefits, the policy shall provide a fixed sum benefit of at least one-fourth of the daily benefit amount payable for hospital confinement for each day of skilled nursing home confinement for at least 100 days, and for each day of home health care for at least 100 days.

(c) A lump sum payment at least equal to \$1,000 may be made to cover non-medical costs such as travel, lodging, household costs, and other living expenses.

(d) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of the covered disease is made at some later date.

(e) No policy shall contain any requirement that the covered person under the policy must incur an expense in order for benefits to be paid.

11:4-53.5 Standards for critical illness coverage

(a) The total benefit amounts available under the policy shall only be available in increments of \$1,000. As long as the policy clearly indicates, in cases of clearly identifiable forms of diseases with significantly lower treatment costs, lesser amounts may be provided, but in no event shall amounts be less than 25 percent of the largest benefit amount under the policy.

(b) The benefit shall be payable upon initial and medically appropriate diagnosis of a specified disease covered by the policy. There shall be no requirement that the insured survive for any period of time in order for the benefit to be payable.

11:4-53.6 Loss ratio standards

(a) In order to assure that benefits are reasonable in relation to the premium charged, the minimum loss ratio for specified disease and critical illness policies shall be as follows:

1. For group policies, at least 75 percent;
2. For individual policies, at least 65 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.

(c) Carriers shall include with the initial submission of rates for a new policy an actuarial memorandum which shall include the following:

1. The anticipated loss ratio;
2. The specific formulas and methodology used in calculating gross premiums;
3. An explanation and documentation supporting the premium assumptions;
4. The objective basis for rate differentials; and
5. A certification signed by the carrier's actuary that the information contained in the actuarial memorandum

is appropriate and that the benefits provided are reasonable in relation to the premiums charged.

(d) The actuarial memorandum submitted to the Department pursuant to (c) above shall be confidential and shall not be considered a public record or disclosed by the Department to any person.

(e) Carriers shall submit for filing with the Commissioner annually on or before June 30 one report for each policy form for which policies issued in New Jersey remain in force in accordance with the applicable reporting form set forth as Exhibit B in the Appendix to this subchapter, incorporated herein by reference.

(f) If the loss ratio for a policy, based on a substantial volume of reasonably mature business, does not meet the standards set forth in (a) above, the carrier shall be required to explain why the premium 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 carrier, the Department shall inform the carrier if the benefits provided are considered unreasonable in relation to the premium charged. If within 90 days thereafter the carrier does not reduce the premium or increase the benefits provided in the policy such that the standards set forth in (a) above are met, the Department may take action and/or impose penalties as may be appropriate pursuant to law. Such action may include the Department's requiring that an independent audit of the carrier's loss ratio be conducted at the carrier's expense.

11:4-53.7 Advertising

(a) Every carrier delivering or issuing for delivery specified disease and critical illness policies or certificates in this State shall file with the Commissioner a copy of all advertisements to which residents of this State shall have access, and through which the carrier intends, or by implication purports to the reasonable targeted consumer its intent, to make its specified disease or critical illness 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 comply with the standards set forth at N.J.A.C. 11:2-11 (the Department's Rules Governing Advertisement of Health Insurance) 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 section or is in violation of N.J.S.A. 17B:30-1 et seq. (the Trade Practices and Discriminations Act). An advertisement which has been disapproved by the Commissioner shall not be utilized until disapproval is withdrawn by the Commissioner.

APPENDIX

EXHIBIT A

(a) To comply with N.J.A.C. 11:4-53.3(b)5, specified disease and critical illness policies meeting the definitions of those terms contained in N.J.A.C. 11:4-53.2 shall use the following statements only, except that appropriate policy identification may be included:

COMPANY NAME

SPECIFIED DISEASE COVERAGE ONLY (CRITICAL ILLNESS COVERAGE ONLY)

OUTLINE OF COVERAGE

This policy or certificate is (an individual policy of insurance) (a group policy or certificate). This policy or certificate provides specified disease coverage (critical illness coverage) ONLY. This policy or certificate does NOT provide comprehensive medical or hospital insurance, Medicare supplement insurance, long-term care insurance, nursing home insurance only, home health care insurance only, or nursing home and home care insurance. You may also contact your local social security office or this company and obtain a copy of the Guide to Health Insurance for People with Medicare.

(Accurately list benefits, exclusions, reductions and limitations of the policy or certificate in a manner which does not misrepresent the actual coverage provided.)

This outline of coverage is a very brief summary of your policy or certificate.

The policy or certificate itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you **READ YOUR POLICY OR CERTIFICATE** carefully.

The anticipated loss ratio for this policy or certificate is *(indicate either 75 percent for group policies, or 65 percent for individual policies)*. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy or certificate.

EXHIBIT B
SPECIFIED DISEASE/CRITICAL ILLNESS POLICY
CALENDAR YEAR EXPERIENCE DATA

CARRIER NAME _____ NAME OF PERSON COMPLETING FORM _____

ADDRESS _____

TITLE _____ PHONE _____

POLICY FORM NO.* _____ DATE _____

DATE POLICY FILED BY NJ _____ ORIGINAL ANTICIPATED LOSS RATIO _____

YEAR	NATIONWIDE DATA				NEW JERSEY DATA			
	#of Policies in Force	Paid Premium	Paid Claims	Loss Ratio	#of Policies in Force	Paid Premium	Paid Claims	Loss Ratio
2001								
2002								
2003								
2004								
2005								
2006								
2007								
2008								
2009								
2010								

* Complete one report for each policy form for which policies issued in New Jersey remain inforce.

Return completed reports to: New Jersey Department of Banking and Insurance
Health Insurance Bureau
PO Box 470
Trenton, NJ 08625