NEW JERSEY REGISTER

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See the Register Index for Subsequent Rulemaking Activity.

NEXT UPDATE: SUPPLEMENT DECEMBER 20, 1993

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On occasion, a proposing agency may extend the 30-day comment period to accommodate public hearings or to elicit greater public response to a proposed new rule or amendment. An extended comment deadline will be noted in the heading of a proposal or appear in a subsequent notice in the Register.

At the close of the period for comments, the proposing agency may thereafter adopt a proposal, without change, or with changes not in violation of the rulemaking procedures at N.J.A.C. 1:30-4.3. The adoption becomes effective upon publication in the Register of a notice of adoption, unless otherwise indicated in the adoption notice. Promulgation in the New Jersey Register establishes a new or amended rule as an official part of the New Jersey Administrative Code.

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Proposals	**January 21**
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March 7 issue:	
Proposals	**February 3**
Adoptions	**February 10**
March 21 issue:	
Proposals	**February 18**
Adoptions	**February 28**

NEW JERSEY REGISTER

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EXECUTIVE ORDER

(a)

OFFICE OF THE GOVERNOR
Governor James J. Florio
Executive Order No. 113 (1993)
Integrated Pest Management

Issued: December 23, 1993.
Effective: December 23, 1993.
Expiration: Indefinite.

WHEREAS, the adoption of new pollution prevention strategies can reduce the levels of toxic compounds present in the indoor and outdoor environment; and

WHEREAS, each State employee has a right to work in a clean and healthy environment, and each citizen of this State has a right to live in a clean environment; and

WHEREAS, approximately three million pounds of chemical pesticides are used in New Jersey each year by licensed applicators; and

WHEREAS, chemical pesticides have been found in many cases to have harmful effects on human health and the environment; and

WHEREAS, Integrated Pest Management (IPM) consists of the use of a combination of pest monitoring, good sanitation practices, appropriate solid waste management, building maintenance, alternative physical, mechanical and biological pest controls, and only as a last resort the use of the least hazardous chemical pesticide; and

WHEREAS, an IPM strategy will provide environmentally-sound, cost-effective methods for controlling pest problems with minimal reliance on chemical pesticides and will help reduce the overall use of chemical pesticides in the State; and

WHEREAS, State agencies have already begun to develop and apply IPM practices, including the use of biological controls for gypsy moths that can damage State parks and forests and the application of other IPM techniques for State mosquito control programs; and

WHEREAS, State agencies have already demonstrated their long-term support for IPM strategies by funding research on state-of-the-art biological pest controls; and

WHEREAS, the implementation of IPM strategies by State agencies can serve as a model for the adoption of similar programs by schools, local governments and private businesses across the State;

NOW, THEREFORE, I, JAMES J. FLORIO, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the statutes of this State, do hereby ORDER and DIRECT:

1. The Department of Environmental Protection and Energy (DEPE) shall implement the following mandates:

A. Conduct a pilot pest control program using IPM techniques for DEPE buildings and grounds. Technical and economic information obtained from this pilot program, which shall be completed within one year of the effective date of this Order, shall be used to provide assistance to other State agencies and instrumentalities on the use of IPM techniques and develop model contract language for State procurement of pest control services utilizing IPM methods;

B. Appoint, within 30 days of the effective date of this Order, a task force to study the potential for increased use of IPM techniques by State agencies. This task force shall include, but need not be limited to, officials and employees from the DEPE, the Department of Treasury and other appropriate State agencies; entomologists or other scientists specializing in IPM techniques; representatives of private firms that provide commercial pest control services, including firms specializing in IPM or organic lawn control methods; and representatives of environmental or other non-profit organizations whose purposes include the study and promotion of IPM methods. No later than one year following the effective date of this Order, this task force shall gather and evaluate technical and economic data on the use of IPM methods by Federal, State or local agencies and private businesses; provide recommendations to the DEPE on the design and implementation of a pilot pest control program; and assist the DEPE in the development of model contract language for State procurement of pest control services utilizing IPM methods;

C. Develop a strategy and timetable for the implementation of IPM pest control measures at facilities owned or operated by State agencies and instrumentalities. This implementation strategy shall include, to the maximum extent practicable, the adoption of model contract language for State procurement of pest control services utilizing IPM methods; and

D. Collect and assess information on the types, quantities and uses of chemical pesticides purchased and applied by State agencies and instrumentalities in both the indoor and outdoor environment, and the development and implementation of any State agency pest control systems using IPM techniques.

2. Each State agency and instrumentality shall cooperate with the DEPE by furnishing information on its use of chemical pesticides and its development and implementation of any pest control programs using IPM techniques.

3. This Order shall take effect immediately.

RULE PROPOSALS

ADMINISTRATIVE LAW

(a)

OFFICE OF ADMINISTRATIVE LAW

Uniform Administrative Procedure Rules
Accelerated Proceedings
Proposed Amendment: N.J.A.C. 1:1-9.4

Authorized By: Jaynee LaVecchia, Director, Office of Administrative Law.
Authority: N.J.S.A. 52:14F-5(e), (f) and (g).
Proposal Number: PRN 1994-38.

Submit comments by February 17, 1994 to:
Jeff S. Masin, Deputy Director
Office of Administrative Law
Quakerbridge Plaza, Bldg. 9, CN 049
Quakerbridge Road
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Uniform Administrative Procedure Rules at N.J.A.C. 1:1 govern the conduct of hearings in contested cases in the executive branch of State government. Provisions at N.J.A.C. 1:1-9.4 provide an accelerated hearing process. If a case is scheduled as an accelerated hearing, the timeframes for the initial and final decisions and exceptions are shortened; formal discovery is not permitted; mediation, prehearing, and settlement conferences are not scheduled; and prehearing motions and posthearing submissions are limited. An accelerated proceeding is scheduled on a party's request if all parties consent, the transmitting agency agrees to the 15-day decision deadline, and the judge assigned to the case finds good cause.

In some instances, requests for acceleration are filed with the OAL before a case has been assigned to, or acted upon by, a judge. In these instances, it will be more expeditious for the Director of the Office of Administrative Law to make the determination on the acceleration request. The proposed rule permits the Director to make that determination if the parties have not yet appeared before the judge either in person, by telephone, or in writing. The rule also allows the Director to assign the acceleration request to a judge.

The proposed amendment requires the requesting party to obtain the consent of all parties, to provide notice of the application to all parties, and to include in the application a statement that all parties consent to acceleration of the case. The rule currently provides that all parties must consent to acceleration. It has been the practice to place the burden of obtaining consent on the party filing the application. Requiring the requesting party to include such consent in its application should simplify and expedite the process.

The proposed amendment also requires filing of the application as soon as circumstances warranting such action are discovered. If possible, the application should be filed with the case pleadings or, if requested by the transmitting agency, upon transmittal. Obviously, if there is a need to accelerate a matter, the process should begin as soon as possible.

The proposed amendment affects the method of applying for acceleration. The accelerated hearing process itself remains unchanged.

This change allows the OAL to resolve acceleration requests more rapidly. It also permits the OAL, in cases where acceleration is granted by the Director, to assign the case to an administrative law judge based upon the scheduling needs of the office and the calendars of the administrative law judges. It should therefore facilitate prompt resolution of these requests and appropriate assignment of the case when acceleration is warranted.

Social Impact

The proposed amendment, by providing that the Director of the OAL can decide acceleration requests prior to involvement in a case by a judge, permits more prompt resolution of these requests and appropriate assignment of the case when such requests are granted. Requiring prompt filing of acceleration applications and requiring the applying party to obtain consent to acceleration should also simplify and expedite the process. It therefore accommodates the needs of the parties for a prompt resolution in certain matters.

Economic Impact

The rule permits requests for accelerations to be decided by the Director of the OAL as well as an administrative law judge. It has no foreseeable economic impact.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendment does not impose reporting, recordkeeping or other compliance requirements on small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendment permits a request for acceleration to be acted upon by the OAL Director if parties have not yet appeared before a judge.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

1:1-9.4 Accelerated proceedings

(a) [Upon written request to the Clerk, with copies to all parties, any] **Any** party may apply for accelerated disposition of a case. The [applicant must state] **application shall be in writing, on notice to all parties, and shall include** the reasons for the request **and a statement that all parties consent to acceleration.**

(b) Applications for acceleration shall be filed as soon as circumstances meriting such action are discovered. Whenever possible, applications for acceleration by a transmitting agency shall be filed upon transmittal of the case and applications for acceleration by any other party shall be filed with the pleadings in the case.

(c) Applications for acceleration shall be made to the Director until such time as a party has appeared before the judge in person, by telephone, or in writing for a motion, prehearing or hearing. The Director may decide the request for acceleration or may assign the motion to the judge for determination. If a party has appeared before the judge in person, by telephone, or in writing for a motion, prehearing, or hearing, applications for acceleration shall be made to the judge.

[(b)]**(d)** If the transmitting agency is a party and the agency either requests accelerated proceedings or concurs in a request for acceleration, the agency will be deemed to have agreed to abide by the 15-day decision deadline in [(c)]**(e)**8 below. If the transmitting agency is not a party, the party requesting acceleration must secure from the transmitting agency agreement to render its final decision within 15 days as provided in [(c)]**(e)**8 below.

[(c)]**(e)** If the transmitting agency agrees to the 15-day decision deadline, all parties consent and **the Director or** the judge assigned to the case then finds that there is good cause for accelerating the proceedings, the judge shall schedule an accelerated hearing date and the case shall proceed in the following manner:

1.-8. (No change.)

AGRICULTURE

(a)

DIVISION OF MARKETS

Agricultural Fairs

Proposed Readoption with Amendments: N.J.A.C. 2:33

Authorized By: State Board of Agriculture and Arthur R. Brown, Jr., Secretary, Department of Agriculture.
Authority: N.J.S.A. 5:8-121 et seq.
Proposal Number: PRN 1994-57.

Submit comments by February 17, 1994 to:
John J. Gallagher, Acting Director
Division of Markets
N.J. Department of Agriculture
CN 330
Trenton, New Jersey 08625
Telephone: (609) 292-5536

The agency proposal follows:

Summary

Historically, a fair certified as an "Official Agricultural Fair" has been eligible for State funds to offset fair expenses and eligible for a license to conduct amusement games at a reduced annual fee. In the past several years, a number of promoters have requested official "agricultural" status for their fairs in order to qualify for the license to conduct amusements games at the reduced annual fee. For this reason, new rules were adopted in 1989.

The Department of Agriculture proposes to readopt the rules with amendments as summarized below:

N.J.A.C. 2:33-1.1 Agricultural fairs: qualifications

N.J.A.C. 2:33-1.1(a) has been recodified into subsections (a) and (b). N.J.A.C. 2:33-1.1(a) requires each "Official Agricultural Fair" to hold, at one site, an agricultural exhibit for the promotion and development of agriculture or agri-business in and of that county. N.J.A.C. 2:33-1.1(b) requires that the fairs conduct at least two additional activities related to manufacturing, community development, product promotion, public service, county interest, culture or recreation. N.J.A.C. 2:33-1.1(c) is recodified from N.J.A.C. 2:33-1.1(b) and requires each "Official Agricultural Fair" to obtain certification from the Department of Agriculture as a condition of operation. N.J.A.C. 2:33-1.1(d) is a new subsection which requires that a fair must be established in the county at least one year prior to application for "Official Agricultural Fair" certification.

N.J.A.C. 2:33-1.2 Responsibilities of certified fair

N.J.A.C. 2:33-1.2(a) requires each certified "Official Agricultural Fair" to furnish a fair status report to the Department of Agriculture; to comply with all governmental health, fire and police regulations, and to furnish on request a copy of the annual fair audit report. N.J.A.C. 2:33-1.2(b) authorizes access to the fair premises by the Department of Agriculture to determine compliance. N.J.A.C. 2:33-1.2(c) is a new subsection that requires "Official Agricultural Fairs" in the same county to hold their fairs a minimum of four weeks apart. Priority for the dates that the fairs will be held will be determined according to the longevity of the respective fairs.

N.J.A.C. 2:33-1.3 Procedure for certification

N.J.A.C. 2:33-1.3(a) currently requires applicants for "Official Agricultural Fair" certification to file their proposal to the Department by May 1 of the year preceding the year the fair is to be held. The proposed amendment would change the filing date to June 1. It also requires a copy be submitted to the county board of agriculture for comment. N.J.A.C. 2:33-1.3(b) currently requires the county board of agriculture to submit comments to the Department on such proposal by June 1. The proposed amendment would change the date to November 1. N.J.A.C. 2:33-1.3(c) requires the State Board of Agriculture to approve or deny certification after consideration of comments from the county board of agriculture.

Social Impact

The proposed readoption with amendments will have a positive social impact upon county boards of agriculture, agricultural youth groups and other agricultural organizations that hold agricultural fairs. The extension of the annual filing period for a proposal for an "Official Agricultural Fair" from May to June of the year prior to the year the fair will be held will allow an organization additional time to plan for their fair. The extension of the proposal comment period for county boards of agriculture from one month to five months should increase interaction of the boards in the certification process and ensure the continuation of quality fairs that showcase New Jersey agriculture.

Economic Impact

The proposed readoption with amendments will, in the absence of State funds to offset the financial burden of "Official Agricultural Fairs," have a negligible economic impact on applicants. The proposed requirement to establish a fair in the county at least one year prior to being certified as an "Official Agricultural Fair" will not economically impact a fair unless games of chance are held. Such a fair would only be negatively impacted for the one year prior to receiving certification. In fact, "Official Agricultural Fairs" qualify for a reduced annual fee for a license to operate games of amusement for which fairs without such certification are not eligible. In addition, the rules will help ensure that "Official Agricultural Fairs" are successful through Department of Agricultural action denying certification of non-agricultural fairs.

Regulatory Flexibility Analysis

Some carnival operators and fair promoters are small businesses, as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules proposed for readoption with amendments may have an economic impact on such businesses, dependent upon whether or not Department of Agriculture certification is obtained for their fair. There is no cost associated with the certification process, the compliance requirements of a certified fair or the reporting requirements other than minimal staff time. The proposed rules, in particular the certification process, are relatively unencumbered, and comply with the legislative mandates of N.J.S.A. 5:8-121 et seq. The required annual fair status report, on Department of Agriculture forms, provides the Department with important information concerning how the fair was conducted to assure proper certification. The report is concise and uncomplicated. The provision of a copy of an annual audit report to the Department upon request was initiated to account for any State funds that were spent by an "Official Agricultural Fair." Such audit reports have not previously been requested and would not be requested in the future without justification. There is currently no State funding, nor is State funding anticipated for agricultural fairs. The proposed rules do not differentiate between small and large businesses, but rather make a distinction between "Official Agricultural Fairs" and other commercial fair or carnival enterprises. The requirements of the rules are felt to be minimal in light of the benefits accrued, reduced annual fees for amusement games, by those participating and are not so burdensome as to necessitate differing standards based on business size.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 2:33.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

2:33-1.1 Agricultural fairs: qualifications

(a) Each person, corporation or association certified as an "Official Agricultural Fair" shall hold, at one site, an agricultural exhibition, whose primary purpose is the development and promotion of several, or many, phases of agriculture or agribusiness in and of that county, by conducting educational programs, activities, demonstrations, contests and exhibitions.

[(a)](b) In addition, the fairs shall conduct two activities related to the following:

1. Manufacturing, commerce and industry;
2. Community development and improvement;
3. Promotion of products and services;
4. Public service events and projects;
5. County interest projects;
6. Cultural works and collections of art;
7. Any activity approved by the entire association for the benefit of the community; and/or
8. Recreational activities.

[(b)](c) No person, corporation or association shall operate a fair or exhibition in any county under the designation "Official Agricul-

tural Fair" without obtaining a certificate to operate from the New Jersey Department of Agriculture.

(d) No person, corporation or association shall be granted an "Official Agricultural Fair" certification prior to having established a fair in that county at least one year prior to their application for said certification.

2:33-1.2 Responsibilities of certified fair

(a) Each person, corporation or association certified as an "Official Agricultural Fair" shall:

1. Furnish annually a [copy of an audit and reports] **detailed fair status report** on forms prescribed by the Department of Agriculture.

2. Comply with all county and municipal health, fire, police and sanitation regulations.

3. Furnish, on request, a copy of the annual fair audit report.

(b) (No change.)

(c) Fairs within the same county shall establish dates to hold their respective fairs with a minimum of four weeks separation. The priority for the establishment of these dates shall be based on the number of years each respective fair has held its fair in that county.

2:33-1.3 Procedure for certification

(a) To receive certification as an "Official Agricultural Fair,"[,] all applicants must annually file their proposals with the Department of Agriculture by [May] **June** 1 of the year preceding the one in which the fair is to be held. A copy shall be submitted to the County Board of Agriculture for its comment.

(b) The County Board of Agriculture shall submit any comments concerning the application to the Department of Agriculture on or before [June] **November** 1 of the year preceding the fair.

(c) After consideration of the [application] **proposal**, and any comments submitted by the County Board of Agriculture, the State Board of Agriculture shall either deny or approve certification of any proposed "Official Agricultural Fair".

BANKING

(a)

DIVISION OF REGULATORY AFFAIRS

Charter Conversions

Proposed Amendments: N.J.A.C. 3:1-2.25 and 2.26; 3:6-8.2 and 8.3

Proposed New Rules: N.J.A.C. 3:6-17

Authorized By: Jeff Connor, Commissioner, Department of Banking.

Authority: N.J.S.A. 17:16M-9 and 17:9A-17.1 Note.

Proposal Number: PRN 1994-47.

Submit comments by February 17, 1994 to:

Rule Comments
Attn: Stephen J. Szabatin, Deputy Commissioner
Department of Banking, CN-040
20 W. State Street
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendments and new rules set forth the application requirements for a charter flip involving a State chartered bank. Public law 1992, c.184, effective December 16, 1992, permitted a savings bank for the first time to convert to a commercial bank, and vice versa. The law requires an applicant for such a conversion to submit to the Commissioner of Banking: (1) copies of the minutes of the meeting of stockholders; (2) a certified copy of the resolution of the board of directors authorizing the conversion; (3) a certificate of incorporation; (4) copies of all applications and approvals from Federal regulators; and (5) other materials as the Commissioner may require by regulation.

The proposed new rules and amendments require, in addition to the above items, biographical information for each of the incorporators and/or directors, a criminal request form, a copy of the bank's most recent quarterly financial report, financial projections for the next three years, a business plan and the required application fee.

The Department may waive any of these application requirements based on the following factors: (1) The financial condition of the institution; (2) Whether the institution was recently chartered; (3) Whether the public would be served by considering the application in an expeditious manner; (4) Whether the conversion is one step in an integrated application; and (5) any other factor which may reflect on the need for a review of all of the materials required.

The law sets a range of fees for a conversion between $5,000 and $10,000. By this rule, the Department sets the fee at $10,000. However, when there is a simultaneous conversion from an association to a savings bank to a bank, or vice versa, the total fee for the two conversions is $10,000, not the statutorily authorized $20,000.

Social Impact

The amendments and new rules specify the application requirements for a charter flip. In this way, the Commissioner will acquire the information necessary to determine whether the interests of the public generally would be jeopardized by the proposed conversion, as required by N.J.S.A. 17:9A-17.4 and 17:16M-4. To this extent, the proposed rules and amendments will have a positive social impact.

Economic Impact

The proposed new rules and amendments require a $10,000 application fee to charter flip. In addition, it requires the applicant to pay the fee for a police check. These charges will have a negative economic impact on applicants for charter flips.

Charter conversions give institutions some latitude in selecting the statutes they operate under and, in some cases, allow them to eliminate redundant levels of supervision. To the extent that the rules facilitate this process, they have a positive economic impact.

Regulatory Flexibility Analysis

Many of the institutions which convert their charters are small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed new rules do impose application requirements on these institutions. However, the information provided by these filings is needed by the Department on all applications, including those of small businesses, so that it may make an informed decision on the application. Accordingly, no differentiation based on business size is made.

In addition, the rules require an application fee of $10,000. This fee reimburses the Department for the administrative cost of processing applications. Since this cost is the same regardless of the size of the applicant, no differentiation based on business size is made.

The charter conversion application process frequently requires the assistance of professional services from an accountant and/or an attorney. However, these services are necessitated by the underlying statutory law, and not by these rules.

Full text of the proposal follows (additions shown in boldface **thus**; deletions indicated by brackets [thus]):

3:1-2.25 Fees, banks and savings banks

(a) A bank or savings bank shall pay to the Commissioner for use of the State the following fees:

1.-9. (No change.)

10. For filing an application for conversion:

i.-ii. (No change.)

iii. From a savings bank to a bank..... $10,000

iv. From a bank to a savings bank..... $10,000

v. From a bank to a savings bank to an association in a simultaneous application..... $10,000

11.-22. (No change.)

(b) (No change.)

3:1-2.26 Fees; State associations

(a) Every State association shall pay to the Commissioner the following fees:

1.-3. (No change.)

4. Application for a conversion:

i.-ii. (No change.)

iii. From an association to a savings bank to a bank in a simultaneous application..... $10,000

5.-21. (No change.)

(b) (No change.)

3:6-8.2 Authorization for conversion

(a) Any mutual savings bank may apply to the Commissioner to convert itself to a mutual association by organizing and transferring its assets and liabilities to a newly-chartered mutual association, and any capital stock savings bank may apply to the Commissioner to convert itself to a capital stock association by organizing and transferring its assets and liabilities to a newly-chartered capital stock association, **and any capital stock savings bank may apply to the Commissioner to convert itself to a bank by organizing and transferring its assets and liabilities to a newly-chartered bank.**

(b) (No change.)

(c) After the board of directors has adopted a resolution, a meeting of the members or stockholders shall be held upon not less than 10 days' written notice. The notice shall contain a statement of the time, place and purpose for which such meeting is called. At this meeting, the members or shareholders shall vote on whether the savings bank shall convert to an association **or bank, as the case may be**. An affirmative vote of at least two-thirds of the members present, or shares eligible to be voted which are represented at the meeting, either in person or by proxy, may approve the conversion.

3:6-8.3 Application for conversion

(a) An application for a conversion from a savings bank to an association **or bank** shall contain the following:

1.-2. (No change.)

3. A certificate of incorporation for the new association **or bank**;

4.-6. (No change.)

7. Financial projections for the converted [associations] **association or bank** for the next three years. Projections shall include a consolidated average balance sheet and a profit and loss statement at the end of each year. **This financial information shall include projections of all relevant regulatory capital requirements as well as appropriate income ratios;**

8. A business plan for three years;

8. and 9. recodified as **9.** and **10.** (No change in text.)

(b) The Department may, in its discretion, waive any of the application requirements of (a) above based on the following:

1. The financial condition of the institution;

2. Whether the institution was recently chartered;

3. Whether the public would be served by considering the application in an expeditious manner;

4. Whether the conversion is one step in an integrated application; and

5. Any other factor which may reflect on the need for a review of all of the materials required in (a) above.

SUBCHAPTER 17. CONVERSIONS OF BANKS

3:6-17.1 Definitions

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

"Bank" shall have the meaning ascribed to it in N.J.S.A. 17:19A-1.

"Capital stock savings bank" shall have the meaning ascribed to it in N.J.S.A. 17:9A-8.1.

3:6-17.2 Authorization for conversion

(a) Any bank may apply to the Commissioner to convert itself to a capital stock savings bank by organizing and transferring its assets and liabilities to a newly-chartered capital stock savings bank.

(b) Before applying to the Commissioner for a conversion pursuant to (a) above, the bank shall obtain a resolution of the bank's board of directors indicating that the conversion is advisable and in the best interests of the shareholders.

(c) After the board of directors has adopted a resolution, a meeting of the members or stockholders shall be held upon not less than 10 days' written notice. The notice shall contain a statement of the time, place and purpose for which such meeting is called. At this meeting, the members or shareholders shall vote on whether the bank shall convert to a capital stock savings bank. An affirmative vote of at least two-thirds of the members present, or shares eligible to be voted which are represented at the meeting, either in person or by proxy, may approve the conversion.

3:6-17.3 Application for conversion

(a) An application for a conversion from a bank to a capital stock savings bank shall contain the following:

1. A certified copy of the resolution of the board of directors authorizing the conversion;

2. A certified copy of the resolution adopted by the stockholders or members relating to the plan of conversion, containing the following information:

i. The total number of votes eligible to be cast;

ii. The total number of votes represented in person or by proxy at the special meeting;

iii. The total number of votes cast in favor and against each matter;

iv. The percentage of votes cast in favor and against each matter.

3. A certificate of incorporation for the new capital stock savings bank.

4. Biographical information for each of the incorporators and/or directors on forms approved by the Commissioner;

5. A completed form from the New Jersey State Police requesting criminal history record information for each director and/or incorporator, along with a cashier's check, certified check or money order for the applicable amount, payable to the State Police, stapled to the front of each form;

6. A copy of the bank's most recent quarterly financial report;

7. Financial projections for the converted capital stock savings bank for the next three years. Projections shall include a consolidated average balance sheet and a profit and loss statement at the end of each year. This financial information should include projections of all relevant regulatory capital requirements as well as appropriate income ratios;

8. A business plan for the capital stock savings bank for three years;

9. Copies of all applications for Federal regulatory approval and all approvals required in connection with the conversion, or, if no application or approval is required, a statement or opinion of counsel to that effect; and

10. The application fee for the conversion.

(b) The Department may, in its discretion, waive any of the application requirements of this rule based on the following:

1. The financial condition of the institution;

2. Whether the institution was recently chartered;

3. Whether the public would be served by considering the application in an expeditious manner;

4. Whether the conversion is one step in an integrated application; and

5. Any other factor which may reflect on the need for a review of all of the materials required in (a) above.

PERSONNEL

(a)

MERIT SYSTEM BOARD

Use of Social Security Numbers

Proposed New Rule: N.J.A.C. 4A:1-2.3

Proposed Amendments: N.J.A.C. 4A:2-3.1, 4A:3-3.1, 4A:4-2.1 and 4A:6-4.2

Authorized By: Merit System Board, Anthony J. Cimino, Commissioner, Department of Personnel.

Authority: N.J.S.A. 11A:2-6(d), 11A:2-11(c), 11A:2-11(h), 11A:3-1, 11A:4-1 and 11A:6-25; 5 U.S.C. 405; and 42 U.S.C. 552a(note).

Proposal Number: PRN 1994-50.

PERSONNEL

A **public hearing** concerning the proposed new rule and amendments will be held on:

Wednesday, February 9, 1994 at 3:00 P.M.
Merit System Board Room
Department of Personnel
44 South Clinton Avenue
Trenton, New Jersey

Please call the Regulations Unit at (609) 984-0118 if you wish to be included on the list of speakers.

Submit written comments by February 17, 1994 to:

Janet Share Zatz
Director of Appellate Practices and Labor Relations
Department of Personnel
CN 312
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Personnel uses Social Security numbers for a number of purposes in fulfilling its statutory responsibilities. Federal law provides, however, that Social Security numbers may be solicited for these purposes only if individuals are informed of the purpose for which the numbers will be used, that provision of such numbers is voluntary, and that requests for such numbers are permissible pursuant to statute or regulation. In order to ensure compliance with these Federal statutes, the Board proposes a new rule and amendments of four rules.

Proposed new rule N.J.A.C. 4A:1-2.3, which is applicable to local service, would require local appointing authorities to provide the Department of Personnel with the Social Security numbers of their employees for purposes of establishing a unique means of identifying their records. To obtain such numbers, local appointing authorities would be required to provide the appropriate notice to their employees. A separate and unique identification number would be assigned by the Department of Personnel to each employee who declines to provide his or her Social Security number. Thereafter, requests for information from the employee or appointing authority must include either the Social Security number or assigned identification number.

The proposed amendment to N.J.A.C. 4A:2-3.1, concerning minor discipline and grievances, would require that minor discipline appeal and grievance forms include a statement indicating the purpose for requesting the Social Security number, that provision of the number is voluntary, and the statutory and regulatory basis for the request.

The proposed amendment to N.J.A.C. 4A:3-3.1, Classification of Positions, would require that position classification questionnaires include a statement indicating the purpose for requesting the Social Security number, that provision of the number is voluntary, and the statutory and regulatory basis for the request.

The proposed amendment to N.J.A.C. 4A:4-2.1, Announcements and Applications, would require a notice to be placed on all open competitive and promotional examination application forms. The notice would state the purpose for which the applicant's Social Security number is requested, that provision of the number is voluntary, and the statutory and regulatory basis for the request. A separate and unique identification number would be assigned by the Department of Personnel to each applicant who declines to provide his or her Social Security number. Thereafter, requests for information from the applicant would have to include the Social Security number or assigned identification number.

Finally, the proposed amendment to N.J.A.C. 4A:6-4.2, concerning training, would authorize the Human Resource Development Institute (HRDI) to request Social Security numbers from all clients, including State government employees. Forms requesting such numbers would state the purpose for which the client's Social Security number is requested, that provision of the number is voluntary, and the statutory and regulatory basis for the request. A separate and unique identification number would be assigned by the Department of Personnel to each client who declines to provide his or her Social Security number. Thereafter, requests for information from the client or appointing authority would have to include the Social Security number or assigned identification number.

Social Impact

The proposed new rule and amendments would not have a major impact upon State and local government employers and employees, examination applicants, and HRDI clients, but would ensure that current practices by the Department of Personnel with regard to Social Security numbers are in conformance with applicable Federal law. Individuals who decline to provide their Social Security numbers may experience some inconvenience, however, particularly in the case of those employees who would need to use a separate identification number in communicating with the Department of Personnel.

Economic Impact

The proposed new rule and amendments would have some economic impact upon State and local government employers, due to the need to revise certain forms and the costs associated with assigning separate identification numbers to individuals who decline to provide their Social Security numbers.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required since the proposed new rule and amendments will have no effect on small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed new rule and amendments will regulate employment in the public sector.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

4A:1-2.3 Employee records: local service

(a) In local service, appointing authorities shall provide a notice to each employee that the Social Security number is requested for purposes of establishing a unique means of identifying the employee's records in the Department of Personnel, that provision of the number is voluntary for this purpose, and that the request for the number is authorized by N.J.S.A. 11A:2-11(c), N.J.A.C. 4A:1-3.2(a)3 and this rule. Appointing authorities shall provide the Department of Personnel with the Social Security number of every employee who provides his or her number in response to such request.

(b) The Department of Personnel will assign a separate and unique identification number to each employee who fails to provide a Social Security number.

(c) Inquiries or requests from an employee or appointing authority regarding that employee must include either the employee's Social Security number or assigned identification number.

(d) It shall be the responsibility of the employee to ensure that his or her records are accurately identified.

4A:2-3.1 General provisions

(a)-(d) (No change.)

(e) Minor discipline appeal and grievance forms shall include a statement that the employee's Social Security number is requested for purposes of matching information and verifying records maintained by the Department of Personnel, that provision of the number is voluntary, and that the request for the number is authorized by N.J.S.A. 11A:2-6, 11A:2-11(h) and this rule.

Recodify existing (e)-(g) as **(f)-(h)** (No change in text.)

4A:3-3.1 Classification of positions

(a)-(d) (No change.)

(e) Position classification questionnaires shall include a statement that the employee's Social Security number is requested for purposes of matching information and verifying records maintained by the Department of Personnel, that provision of the number is voluntary, and that the request for the number is authorized by N.J.S.A. 11A:2-11(c) and (h), 11A:3-1 and this rule.

Recodify existing (e) as **(f)** (No change in text.)

4A:4-2.1 Announcements and applications

(a)-(d) No change.)

(e) Applications for open competitive and local service promotional examinations shall be filed with the Department of Personnel and applications for State service promotional examinations shall be filed with the appointing authority no later than the announced filing date, which in no case shall be less than two weeks after the announcement. When mailed, the postmark date will be considered the date on which the application is filed.

1. Application forms shall include a statement that the applicant's Social Security number is requested for purposes of

establishing a unique means of identifying his or her records throughout the selection and appointment process, that provision of the number is voluntary, and that the request for the number is authorized by N.J.S.A. 11A:4-1 and this rule.

2. The Department of Personnel will assign a separate and unique identification number to each individual who fails to include the Social Security number on applications filed. The unique identification number will appear on all subsequent notices and examination records related to that individual's applications. Inquiries or requests from an applicant regarding those applications, or other examination records relating to them, must include either the applicant's Social Security number or the assigned identification number.

(f)-(i) (No change.)

4A:6-4.2 Department of Personnel functions: State service

(a)-(d) (No change.)

(e) The Institute shall maintain a comprehensive system to record the training and education experiences of its clients, including all State government employees.

1. The Institute shall request each client to provide his or her Social Security number. All forms requesting such numbers shall include a statement that the client's Social Security number is requested for purposes of maintaining a comprehensive system to record the training and educational experiences of the Institute's clients and retrieving data as necessary for required Federal and State government reports, that provision of the number is voluntary, and that the request for the number is authorized by N.J.S.A. 11A:6-25 and this rule.

2. The Institute will assign a separate and unique identification number to each client who fails to provide a Social Security number. Inquiries or requests from a client or appointing authority regarding that client must include the employee's Social Security number or assigned identification number. It shall be the responsibility of the client to ensure that his or her records are accurately identified.

(f) (No change.)

COMMUNITY AFFAIRS

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Relocation Assistance and Eviction

Proposed Readoption with Amendments: N.J.A.C. 5:11

Authorized By: Stephanie R. Bush, Commissioner, Department of Community Affairs.

Authority: N.J.S.A. 2A:18-61.1, 20:4-10 and 52:31B-10.

Proposal Number: PRN 1994-63.

Submit written comments by February 17, 1994 to:

Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, New Jersey 08625
FAX No. (609) 633-6729

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), the Relocation Assistance and Eviction rules, N.J.A.C. 5:11, are scheduled to expire on March 10, 1994. The Department has reviewed these rules and finds that they continue to be necessary for the fair and orderly administration of the relocation assistance statutes (N.J.S.A. 52:31B-1 et seq. and 20:4-1 et seq.) and related provisions of the fair cause for eviction statute (N.J.S.A. 2A:18-61.1 et seq.)

Under the relocation assistance statutes, as implemented by N.J.A.C. 5:11, individuals, businesses and farming operations displaced by property acquisition activities of public entities, public funded entities and public utilities are entitled to receive financial benefits and other assistance in finding suitable alternative facilities. These benefits are also provided to persons displaced by various code enforcement activities. The State of New Jersey, through the Department of Community Affairs, provides grants to local governments that file Workable Relocation Assistance Plans, as well as direct assistance to persons displaced by the Department's own code enforcement activities.

Several amendments are being made for purposes of clarification and conformity to statute and to update designation of units within the Department. Of these, the most significant is the addition of language proposed at N.J.A.C. 5:11-2.1(b)1 making it clear that the exclusion from relocation assistance eligibility for displacement as a result of construction code enforcement applies only in those cases in which there is a direct and immediate threat to the lives of persons within the building, as when a code official tells people to get out of a building immediately because it could collapse at any time.

Other amendments include: conforming the definition of "person" to the definitions in the relocation statutes at N.J.A.C. 5:11-1.2; making it clear that moving expenses for a distance of 50 miles or less shall not be considered unreasonable and that longer moves may also be deemed reasonable for good cause at N.J.A.C. 5:11-3.2(b); that payments for temporary relocation need not be made in a single lump sum at N.J.A.C. 5:11-3.3; that a file may be closed, subject to future reactivation, if a tenant fails to appear for payment when due at N.J.A.C. 5:11-3.5(c)2; and that the filing of monthly progress reports by displacing agencies will not be required at N.J.A.C. 5:11-6.3.

Social Impact

Failure to readopt these rules would adversely affect both displacing agencies, which would lack the necessary guidelines for discharging their statutory relocation obligations, and the persons entitled by law to receive relocation assistance. The proposed amendments will provide clarification with regard to various issues that have arisen in the past few years and will enable both displaced persons and displacing agencies to better understand their rights and responsibilities.

Economic Impact

The proposed amendments will reduce the likelihood of persons either not getting benefits to which they are entitled or getting excessive benefits due to non-uniform interpretation of the rules.

In Fiscal Year 1993, grants totalling $252,144 were provided to 20 municipalities and county agencies. These grants were used to provide relocation assistance to 352 families, 24 individuals and six businesses. An additional $80,692 was expended by the Department directly for the relocation of 75 families and individuals displaced by code enforcement activity.

Regulatory Flexibility Statement

The rules proposed for readoption, as amended, do not impose reporting or recordkeeping requirements upon small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. However, a small business that applies for relocation assistance will have to be in a position to document any benefit claims that it makes. There are no procedural requirements for establishing and documenting a claim that would create any hardship for any business, large or small, that has maintained necessary records in an appropriate manner.

Residential landlords who qualify as small businesses are affected by the procedures required to be followed in code enforcement related evictions. However, these procedures are simple and straightforward and should not, in the judgment of the Department, impose any particular hardship upon landlords.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 5:11.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]).

5:11-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context or any definition set forth in P.L.1967, c.79 (N.J.S.A. [53:31B-1] **52:31B-1** et seq.) or P.L.1971, c.362 (N.J.S.A. 20:4-1 et seq.) clearly indicates otherwise.

. . .

"[Persons] **Person**" means [those terms as defined in N.J.S.A. 1:1-2] **any individual or family, owner of a business concern or farm operation, partnership, corporation or association.**

. . .

5:11-2.1 Building, housing, and health code enforcement

(a) Whenever a State Agency or unit of local government undertakes a program of building code enforcement, housing code enforcement or health code enforcement that causes the displacement of [people, businesses or farm operations] **any person,** the said State Agency or unit of local government shall provide relocation payments and assistance to all lawful occupants who are displaced, as provided in [subchapters 3 and 4 of this chapter] **N.J.A.C. 5:11-3 and 4.** The date of eligibility shall be the date occupants received formal written notice to vacate from the State Agency or unit of local government.

(b) Whenever the displacement occurs because of an order to vacate issued by a State Agency or unit of local government as a direct result of a natural disaster, an imminent hazard to life safety necessitating the issuance of a vacate order pursuant to the State Uniform Construction Code Act (N.J.S.A. 52:27D-119 et seq.) or fire, there shall **be**, except as may otherwise be expressly provided by [statute] **N.J.S.A. 20:4-3.1**, [be] no relocation benefits due the [displaces, provided, however, that] **displacees. However,** a municipality may provide [such] **relocation** benefits to [fire victims] **such displacees** but shall receive no reimbursement through any State grant-in-aid, except as may otherwise be expressly provided by statute, for the cost of doing so.

1. For purposes of this subsection, only a condition that is a direct and immediate threat to the lives of persons within the building, and cited as such by the construction official under N.J.A.C. 5:23-2.32(b)1, shall be deemed to be an imminent hazard to life safety.

(c)-(d) (No change.)

5:11-2.3 Evictions under N.J.S.A. 2A:18-61.1(g)

(a)-(b) (No change.)

(c) In cases where a landlord is to be cited for a violation pursuant to an illegal occupancy which could potentially result in a g(3) eviction, the following shall be included as an insert sent with the violation notice:

IF, IN SEEKING TO CORRECT THE ILLEGAL OCCUPANCY FOR WHICH YOU HAVE BEEN CITED, IT IS NECESSARY FOR YOU TO EVICT ONE OR MORE TENANTS TO COMPLY, YOU MUST NOTIFY THOSE TENANTS OF THEIR POTENTIAL ELIGIBILITY FOR RELOCATION ASSISTANCE. FURTHER INFORMATION REGARDING YOUR RESPONSIBILITIES AS OWNER PURSUANT TO REGULATIONS CONCERNING EVICTION AND RELOCATION MAY BE OBTAINED BY CONTACTING THE FOLLOWING:

DEPARTMENT OF COMMUNITY AFFAIRS
DIVISION OF HOUSING AND DEVELOPMENT
OFFICE OF LANDLORD-TENANT [RELATIONS]
INFORMATION
CN [804] **805**
TRENTON, NEW JERSEY 08625-0805
TELEPHONE: 609-[292-6417] **530-5423**

5:11-3.2 Moving expenses; residential

(a) An eligible [individual] **person** who is displaced from a dwelling unit and moves his **or her** personal property therefrom shall receive either:

1. The actual reasonable moving expenses incurred[,]; or

2. A fixed payment, based on the number of rooms in the unit, not to exceed $300.00 and a $200.00 dislocation allowance.

(b) Moving expenses shall not be considered unreasonable due to distance if the distance is 50 miles or less. For good cause, a move of more than 50 miles may be deemed reasonable by the displacing agency.

5:11-3.3 Emergency relocation

In the event a displacing agency causes a displacement that requires emergency relocation, the displacing agency shall provide a [lump sum] payment of such amount as may be needed so that the displacee may obtain living quarters until permanently relocated. This payment shall be available immediately upon the displacement and shall be charged against the total **relocation assistance** amount payable in accordance with the statute.

5:11-3.5 Rental assistance payments

(a)-(b) (No change.)

(c) If the rental assistance payment exceeds $1,000, the displacing agency shall make the payment in three equal annual installments[,] upon verification that the tenant remains in comparable standard housing and that rent payments are current, unless the relocation agency finds **that** there [to be] **exists a** reasonable cause for any non-payment of rent.

1. (No change.)

2. If the rental assistance payments are not consecutive because the tenant moved into substandard housing or moved outside the authorized area **or failed to appear for payment when due,** the tenant, if he **or she** is no longer living in substandard housing or outside the authorized area, [may] **must** reactivate his **or her** claim within one year of the last prior date on which he **or she** would have been eligible to receive the rental assistance payment.

(d)-(f) (No change.)

5:11-6.3 Relocation records and reports

(a) The displacing agency is responsible for keeping up-to-date records on the relocation of all site displacees. These records shall be retained [by] **for** the Department's inspection and audit for a period of three years following completion of the project or program or the completion of the making of relocation payments, whichever is later. [The displacing agency is also responsible for maintaining and submitting to the Department monthly progress reports on relocation.]

1. (No change.)

5:11-7.2 Additional notice for proceedings under N.J.S.A. 2A:18-61.1(g)

(a)-(b) (No change.)

(c) Landlords may obtain copies of this required statement from the Office of Landlord/Tenant [Relations] **Information**, Department of Community Affairs, CN [804] **805**, Trenton, N.J. 08625-**0805**. Spanish speaking tenants shall be provided with this statement in Spanish, and such statement is also available at the same address.

5:11-8.2 Funding criteria

(a) A municipality meeting the following criteria may receive the total cost of relocation assistance and payments.

1.-3. (No change.)

4. A lack of other state or federal funding **for the purpose of relocation assistance**.

(b)-(c) (No change.)

5:11-9.1 Administrative agency

These rules shall be administered by the [Bureau of] Housing **Production** and Community Development **Element** of the Division of Housing and Development, Department of Community Affairs, CN-806, Trenton, New Jersey 08625-**0806**.

5:11-9.2 Right of hearing and time for filing

(a) Any person aggrieved by a final determination by a displacing agency other than a State agency may appeal such determination to the [Bureau of] Housing **Production** and Community Development **Element**, which shall thoroughly review the matter and issue its findings as to the merits of the claim for relocation payments or benefits. Such appeals shall be made **in writing** within 15 **calendar** days of receipt of written notice of the determination.

(b) The Division of Housing and Development shall provide an administrative hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., to any person aggrieved either by a final determination of a displacing agency which is a State agency or by findings issued by the [Bureau of] Housing **Production** and Community Development **Element** pursuant to (a) above.

1. Such hearing shall be conducted under the auspices of the Office of Administrative Law and the final decision shall be made by the Commissioner.

2. Any request for a hearing shall be made **in writing** within 15 days of receipt of written notice of the State agency determination or the findings of the [Bureau of] Housing **Production** and Community Development **Element**, as the case may be.

(c) The parties to any hearing before the Office of Administrative Law shall be the displacing agency and the person aggrieved by the final determination of such agency.

1. Representatives of the [Bureau of] Housing **Production** and Community Development **Element** may appear at any such hearing to testify as to the findings of the [Bureau] **Element**.

2. In all cases which it has reviewed, the [Bureau] **Element** shall provide the Office of Administrative Law and the parties with a determination memorandum setting forth the claims of the parties, the facts as determined by the [Bureau] **Element**, the regulations, statutory provisions and case law which the [Bureau] **Element** deems to be applicable, and the [Bureau's] **Element's** conclusions and the reason therefor.

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

DIVISION OF FISH, GAME AND WILDLIFE

Marine Fisheries

Size and Possession Limits; Pound Nets

Proposed Amendments: N.J.A.C. 7:25-18.1 and 18.2

Authorized By: Jeanne M. Fox, Acting Commissioner, Department of Environmental Protection and Energy.

Authority: N.J.S.A. 23:2B-6, 23:2B-14 and 23:5-45.

DEPE Docket Number: 66-93-12/319.

Proposal Number: PRN 1994-59.

Public hearing on the proposal will be held on:

Monday, February 7, 1994 at 7:30 P.M.
Rutgers Cooperative Extension
of Cape May County
Dennisville Road (Route 657)
Cape May Court House, New Jersey

and

Thursday, February 10, 1994 at 7:30 P.M.
Ocean County Administration Building
Room 119
101 Hooper Avenue
Toms River, New Jersey

Submit written comments by the Docket Number given above, by February 17, 1994 to:

Janis E. Hoagland, Esq.
Office of Legal Affairs
Department of Environmental Protection
and Energy
CN 402
Trenton, NJ 08625

The agency proposal follows:

Summary

The Marine Fisheries Council has reviewed and approved the following proposed rule amendments.

The purpose of the proposed amendment to N.J.A.C. 7:25-18.1 is to establish minimum possession size limits for tautog (also known as blackfish) (*Tautoga onitis*), Spanish mackerel (*Scomberomorus maculatus*), king mackerel (*Scomberomorus cavalla*), cobia (*Rachycentron canadum*), cod (*Gadus morhua*), haddock (*Melanogrammus aeglefinus*), pollock (*Pollachius virens*), goosefish (*Lophius americanus*), increase the minimum size limit on red drum (*Sciaenops ocellatus*) and change the size limit for striped bass hybrids to no less than the striped bass minimum size limits established pursuant to N.J.S.A. 23:5-45.1.

The amendment will also establish a possession limit of one fish that is either a striped bass or striped bass hybrid and include striped bass hybrids in the season closures, as well as extending the southern terminus of the Delaware River spawning area closure down to and including the Salem River and its tributaries. A daily possession limit for Spanish and king mackerel, red drum and cobia of 10, five, five and two fish, respectively, is also proposed.

Division enforcement personnel have experienced an increased number of fishermen in possession of striped bass below the minimum legal size limit who claim that the sublegal striped bass are actually striped bass hybrids. Current minimum size limits for striped bass are 28 inches along the Atlantic coast including bays, rivers and tributaries and 36 inches for Delaware Bay, Delaware River and their tributaries. Striped bass hybrids, on the other hand, have a current minimum size limit of 16 inches throughout the State. The disparity in minimum legal size limits between these two fish with considerable similarities in appearance, at times leaves fishermen in doubt as to the appropriate size limit. This disparity also enables some unresponsive fishermen to circumvent the minimum size limits for striped bass. In order to enhance certainty and to facilitate enforcement of the minimum size limit for striped bass, the minimum size limit for striped bass hybrids will be increased from 16 inches to the equivalent minimum legal size limits for striped bass established pursuant to N.J.S.A. 23:5-45.1 (28 inches on the Atlantic Coast and 36 inches in the Delaware Bay, River and their tributaries).

The current possession limit for striped bass hybrids is no more than two fish per person per day. The current striped bass possession limit is no more than one fish per person per day (excluding the striped bass trophy fish program with its special tagging requirement). The proposed amendment establishes a maximum possession limit of one fish regardless of whether it is a striped bass or a striped bass hybrid. In other words, a possession limit of one fish of either species and not one fish of each species. This new possession limit will facilitate the certainty and enforcement of the existing striped bass possession limit established pursuant to N.J.S.A. 23:5-45.1. Fishermen could not confuse or circumvent the striped bass possession limit of one fish per person per day by having more than one striped bass and claiming that the second and third fish are striped bass hybrids.

There is currently a spawning season closure for a portion of the Delaware River from April 1 through May 31 of each year. The Delaware River closure is designed to afford added management protection to the Delaware River striped bass population which is still recovering from near decimation that occurred during the early decades of this century. The spawning season closure is designed to reduce the fishing mortality of spawning fish. The closure presently exists for that portion of the Delaware River or its tributaries from the Trenton Falls downstream to the northernmost border shared by New Jersey and Delaware. The area described was found insufficient to effectively protect the entire striped bass spawning habitat. Since the State of Delaware's boundary line extends to the mean low water line on the New Jersey side of the Delaware River below the northernmost border shared by New Jersey and Delaware, bank fishermen in New Jersey could cast and catch striped bass in Delaware waters where a spawning area closure existed, but legally land the fish in New Jersey because no spawning area closure existed in those waters between high and low tide lines. By extending the southern terminus of New Jersey's spawning area closure in the Delaware River downstream to and including the Salem River and its tributaries, fishing mortality of the spawning striped bass population is reduced and this loophole is closed. Including striped bass hybrids in the striped bass season closures also reduces fishing mortality of the striped bass population since fishermen would not confuse striped bass hybrids with striped bass nor could fishermen possess a striped bass during the closure and claim the striped bass are actually striped bass hybrids.

The proposed amendment also more clearly defines the reporting requirements of participants in the Striped Bass Trophy Fish Program and establishes penalties for non-compliance with the program's reporting requirements. Accurate monitoring of the Striped Bass Trophy Fish Program is essential to ensure the program landings do not exceed the State's annual quota of 63,800 pounds established by the Atlantic States Marine Fisheries Commission. End of season reporting forms are distributed to all participants of the Striped Bass Trophy Fish Program. Participants are already required to keep records and complete forms each year. The intent of this proposal is to better manage the striped bass resource. During the last two years, only ten percent of the trophy program participants have returned their end of season report. The regulation is being modified to clarify that trophy fish program participants must keep **and submit** annual records of all their striped bass fishing activity as requested on forms furnished by the Division. Failure to comply with reporting requirements will result in revocation from the program and require returning any trophy fish program fish possession

tag to the Division. Failure to return the fish possession tag upon request by the Division might also result in the imposition of penalties prescribed by N.J.S.A. 23:2B-14.

The proposed size and possession limits for Spanish mackerel, king mackerel, red drum and cobia are proposed at the request of the National Marine Fisheries Service (NMFS) and the Gulf of Mexico and South Atlantic Fishery Management Councils. The purpose of these provisions is to rebuild mackerel resources and to protect red drum and cobia stocks. The size limits for cod, haddock and pollock are proposed at the request of the NMFS to conserve resources and to achieve consistency with the existing size limits in Federal waters off the New Jersey coast. The minimum size limit for goosefish is proposed at the request of the Mid-Atlantic Fishery Management Council to discourage development of a commercial fishery on small fish.

A valuable market for goosefish livers has emerged. Therefore, in addition to the minimum size limit, a minimum weight for goosefish livers is proposed. The minimum goosefish liver weight will discourage the offshore removal of livers from goosefish smaller than the minimum size. Failure to establish the minimum liver weight will compromise the effectiveness of the minimum size limit. The proposed minimum liver weight is based upon the proposed minimum goosefish size limit.

The proposed minimum size limit on tautog of 12 inches will be phased in over a period of three years beginning at 10 inches and being raised an inch each January 1 until 12 inches is attained. The phase-in is a recommendation of the New Jersey Marine Fisheries Council's Tautog Committee comprised of representatives from the recreational fishery, as well as the party and charter boat industry and the commercial fishery so as to conserve the species and minimize any impact on the recreational fishery, party and charter boat industries.

The proposed amendment to N.J.A.C. 7:25-18.2 deletes specific references to minimum size limits of fish taken in pound nets. These deletions reduce redundancy. The size limits specified in N.J.A.C. 7:25-18.1 are applicable to pound nets. The amendment also specifies that the procedure presently used to acquire pound net sites in Raritan and Sandy Hook bays shall also be extended to and used in Delaware Bay.

Social Impact

The proposed amendment to N.J.A.C. 7:25-18.1 will establish size and possession limits for Spanish and king mackerel, red drum and cobia at the request of the Gulf of Mexico and South Atlantic Fishery Management Councils and size limits on cod, haddock, pollock, goosefish and tautog.

The establishment of size and possession limits for Spanish and king mackerel, red drum and cobia will result in minor social impacts. Owing to effective resource management, the status of these resources is currently improving. As a result of their increased population, these species are expanding their traditional range northerly into waters of New Jersey. The proposed minimum size limits and possession limits are consistent with management measures in Federal waters (greater than three miles from shore) off New Jersey. New Jersey fishermen have only begun to harvest these species in recent years. Thus, the social impacts associated with the establishment of minimum size and possession limts will be minimal, especially with their imposition before a significant fishery develops.

The proposed size limit on cod, haddock and pollock for New Jersey waters is already in effect in Federal waters and should not result in any significant social impact. Identical size limits for these species in State and Federal waters will eliminate a potential enforcement loophole. The proposed size limit on goosefish is below the size of goosefish currently being harvested by New Jersey commercial fishermen. The goosefish minimum liver weight is based upon the minimum size proposed. Therefore no social impact is anticipated.

The size limit on tautog should have a minor social impact. The Marine Fisheries Council's Tautog Committee comprised of representatives from the commercial fishery, recreational fishery and the party and charter boat fishery do not foresee any problems with increasing the size limit. To minimize any adverse impacts of the desired 12 inch minimum size limit, it will be phased in over a three year period beginning at 10 inches in 1994 and being increased one inch per year until it reaches 12 inches.

Greater fishing opportunities will result as the resources expand from prudent management, a longterm positive social impact.

The striped bass hybrid proposal will enhance certainty among fishermen and to facilitate enforcement of minimum size limits, daily possession limits, and season closures for striped bass. Adjusting the striped bass hybrid minimum size limit and reducing and combining the hybrid daily possession limit with the striped bass daily possession limit for a total daily possession limit of one fish per person, may have minor social impact since a fishermen's potential daily harvest of striped bass hybrids will be reduced. Inclusion of the striped bass hybrid in the season closures may also limit some fishermen in their pursuit of striped bass hybrids. These impacts should be minimal however, given the low level of striped bass hybrids in estuarine and marine waters in New Jersey as documented through the Striped Bass Tagging Project that has been conducted by the Department since 1989.

The proposed striped bass trophy program amendment will more clearly explain the reporting requirements of participants in the Striped Bass Trophy Fish Program and establish penalties for noncompliance; these obligations will have a minor social impact. Trophy fish program participation is voluntary. Fishermen voluntarily apply to the Division to obtain a fish possession tag that permits them to keep a trophy striped bass in addition to their regular recreational striped bass catch. Completion of end of season reporting forms is already required of each trophy fish program participant. Therefore, only minor social impact will be experienced by fishermen since the amendment would clarify the intent of the regulation and merely require submittal of the presently required annual reports and remove noncompliant participants from the program for failure to report. The Division needs the striped bass fishing activity data to continue the program. Submittal of season reporting forms by participants in the trophy fish program will furnish valuable data for the Division to effectively monitor the striped bass sportfishery. The Division is required by the Atlantic States Marine Fisheries Commission (ASMFC) to monitor the State's saltwater striped bass sportfishery with precision and accuracy as outlined in the Inter-State Fisheries Management Plan for Striped Bass (Plan). Failure to comply with the ASMFC Plan could result in a Federally enforced striped bass fishing moratorium.

Establishing a pound net licensing procedure for Delaware Bay, as currently exists in Raritan and Sandy Hook Bays, will also have a positive social impact by establishing a consistent approach to pound net licensing. Deleting the reference to size limits under the pound net section will eliminate redundancy and public confusion.

Economic Impact

The economic impact of the proposed amendments should be minimal. The economic impact of the size limits on cod, haddock and pollock and the size and possession limits for Spanish and king mackerel, red drum and cobia should be minimal. These proposed size limits would be consistent with those in effect in Federal waters. Since these species are primarily harvested in Federal waters, the imposition of these restrictions in New Jersey waters should not result in any adverse economic impacts. The economic impact from the proposed minimum goosefish size and liver weight also should be minimal because the existing New Jersey commercial fishery for this species harvests goosefish larger than the proposed minimum size.

The possession size limit on tautog (blackfish) should have a minor economic impact. The Marine Fisheries Council's Tautog Committee, comprised of representatives from the commercial fishery, recreational fishery as well as the party and charter boat fishery, do not foresee any problems with a possession size limit. To minimize any adverse impacts from the desired 12 inch minimum size limit, it will be phased in over a three year period beginning at 10 inches in 1994 and being increased one inch per year until it reaches 12 inches.

The longterm economic impact from size and possession limits on these resources should be positive. By protecting these species

while the resources are still at low population levels, increased fishing opportunities and the associated economic benefits are likely to occur in the future.

Striped bass hybrid fishing activity may decrease slightly during the season closures but any hybrid fishery that may exist in estuarine waters is so small that any economic impact would be minimal. The economic impact of the increased minimum size limit and reduced bag limit for striped bass hybrids will be slight or non-existent, owing to their low level of incidence in the estuarine and marine waters of New Jersey. Striped bass hybrids which are products of commercial aquaculture continue to be exempt from size and possession limits and the amendment will have no economic impact on commercial fishing operations, since they do not currently harvest significant numbers of hybrid striped bass.

The economic impact of the proposal for new trophy fish reporting requirements should be minimal. The Division already furnishes standardized end of season reporting forms for participants to record their annual striped bass fishing activity data. The only added expense to trophy fish program participants from the rule amendment would be the cost associated with returning the form for monitoring purposes.

The extension of the pound net licensing application procedure to the Delaware Bay will conform to the application procedure now used in Raritan and Sandy Hook bays. There is no fee for the application and the $100.00 pound net license fee already applicable will remain in effect.

Environmental Impact

The proposed amendment concerning Spanish and king mackerel, red drum and cobia should result in a positive environmental impact. The population of these resources is currently increasing and, therefore, expanding its range and becoming more abundant in New Jersey waters. The goal of the Federal Gulf of Mexico and South Atlantic Councils is to protect the red drum and cobia stocks and to increase the mackerel stocks. Adoption of the amendment will result in consistent management measures for these species throughout their range, thus enhancing chances of faster stock recovery from low population levels. The size limits established for cod, haddock and pollock will protect these species in a consistent manner with the same size limits in effect in Federal waters and will help increase and/or maintain existing stock levels.

The proposed size limit for commercial fishermen on goosefish should have a positive environmental impact. The existing New Jersey commercial fishery for this species generally harvests larger fish. However, the Mid-Atlantic Fishery Management Council is concerned that as the goosefish resource continues to decline there will be more harvesting effort directed toward smaller fish. The proposed minimum size limit and liver weight will discourage fishermen from harvesting smaller fish thus benefiting the goosefish resource.

Establishment of a minimum possession size limit for tautog should result in a positive environmental impact for this species. The tautog is a slow growing long lived fish and it is essential to ensure that it has sufficient opportunity to spawn before being harvested.

The proposed amendments should have a positive environmental impact on the striped bass resource, since all current striped bass management measures as specified in the ASMFC Plan for resource recovery will be enforced. Fishing mortality will be reduced on the striped bass resource since sub-legal striped bass will not be harvested by inaccurately believing or claiming the fish to be hybrids.

The spawning area closure extension in the Delaware River downstream to and including the Salem River and its tributaries will provide added protection to the Delaware River striped bass population during the spawning season. No longer could fishermen exploit an unintended loophole in the rule and harvest striped bass during the spawning season in the Delaware River.

The striped bass hybrids will also experience a positive environmental impact with the adoption of the higher striped bass minimum size limits, thereby reducing the fishing mortality of hybrids for most if not all of their natural lives. This protection of hybrids is a consequence of the need for better striped bass resource protection.

The amendment concerning Striped Bass Trophy Fish Program reporting requirements should have no environmental impact.

The licensing procedure proposed for pound nets in Delaware Bay will have no environmental impact.

Regulatory Flexibility Analysis

The proposed amendments apply to recreational and commercial fishermen and party and charter boats fishing for striped bass, striped bass hybrids, Spanish mackerel, king mackerel, red drum, cobia, goosefish, cod, pollock, haddock and tautog. Most of the commercial fishermen and party and charter boats would be defined as small businesses in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:43-16 et seq. Although these businesses would have to comply with the provisions of the regulations, the minimal added recordkeeping requirements proposed for the pound net application procedure in Delaware Bay already govern pound net applications in Raritan and Sandy Hook Bays. No capital costs will be incurred by these small businesses in order to comply with these proposed amendments. The Striped Bass Trophy Fish Program is a recreational fishery. Therefore, the reporting requirement associated with this program will not impact any small business.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:25-18.1 Size and possession limits

(a) A person shall not purchase, sell, offer for sale, or expose for sale any [codfish measuring less than 12 inches in length, bluefish measuring less than nine inches in length, sea bass or kingfish measuring less than eight inches in length, blackfish, mackerel, or porgy measuring less than seven inches in length.] **species listed below less than the minimum length, measured in inches. Full length shall be measured from the tip of the snout to the tip of the tail.**

Species	Scientific Name	Minimum Size (inches)
Atlantic Mackerel	***Scomber scombrus***	**7**
Black Sea Bass	***Centropristis striata***	**8**
Bluefish	***Pomatomus saltatrix***	**9**
Kingfish	***Menticirrhus saxatilis*** ***Menticirrhus americanus***	**8**
Porgy (Scup)	***Stenotomus chrysops***	**7**
Goosefish (Monkfish)	***Lophius americanus***	**17**

In addition to the total minimum goosefish size, all goosefish tails possessed must be at least 11 inches in length from the anterior portion of the fourth cephalic dorsal spine to the end of the caudal fin. The total weight of all goosefish livers landed shall not be more than 30 percent of the total weight of all goosefish tails landed or 12 percent of the total weight of all goosefish landed.

(b) A person shall not take from the marine waters in the State or have in his possession any [summer flounder, commonly called fluke, under 14 inches in length, winter flounder under 10 inches in length, red drum under 14 inches in length, Atlantic sturgeon under 60 inches in length, or weakfish under 13 inches in length] **species listed below less than the minimum length, measured in inches,** except as provided in N.J.A.C. 7:25-18.14. **Fish length shall be measured from the tip of the snout to the tip of the tail.**

Species	Scientific Name	Minimum Size (inches)
Atlantic Cod	*Gadus morhua*	19
Atlantic Sturgeon	*Acipenser oxyrhynchus*	60
Cobia	*Rachycentron canadum*	37
Haddock	*Melanogrammus aeglefinus*	19
King Mackerel	*Scomberomorus cavalla*	23
Pollock	*Pollachius virens*	19
Red Drum	*Sciaenops ocellatus*	18
Spanish Mackerel	*Scomberomorus maculatus*	14
Summer Flounder (Fluke)	*Paralichthys dentatus*	14
Tautog (Blackfish), through December 31, 1994	*Tautoga onitis*	10
Tautog (Blackfish), through December 31, 1995	*Tautoga onitis*	11
Tautog (Blackfish), beginning January 1, 1996 and thereafter	*Tautoga onitis*	12
Weakfish	*Cynoscion regalis* *Cynoscion nebulosus*	13
Winter Flounder	*Pleuronectes americanus*	10

(c) (No change.)

(d) A person shall not possess at any one time more than [two] **five** red drum [both measuring in excess of 32] **only one of which may be in excess of 27** inches in length, **nor shall any person angling with a hand line or with rod and line or spearfishing possess more than five king mackerel, more than 10 Spanish mackerel, or more than two cobia.**

(e)-(g) (No change.)

(h) A person shall not take, attempt to take or have in his or her possession any striped bass **or striped bass hybrids, as defined in (i) below,** while on or angling in [that portion of] **the waters of the State of New Jersey within the** Delaware River or its tributaries from the Trenton Falls to [the northernmost border shared by the States of New Jersey and Delaware] **and including the Salem River and its tributaries** from April 1 through May 31 of each year, **or from any waters of the State, except the Atlantic Ocean, from January 1 through February 28 of each year as set forth in N.J.S.A. 23:5-45.2.**

(i) Except for products of commercial aquaculture, no person shall take from the marine waters in this State or have in his or her possession **while on or angling in the marine waters of this State** any striped bass hybrids, being hybrids of the Morone genus, [under 16 inches in length] **less than the striped bass minimum size limits established pursuant to N.J.S.A. 23:5-45.1.**

1.-2. (No change.)

(j) Except for **striped bass hybrids that are** the products of commercial aquaculture, a person shall not have more than **a total of one fish that is either a** [two] striped bass [hybrids] **or striped bass hybrid** in his or her possession [at any time] **while on or angling in the marine waters of this State.**

(k)-(m) (No change.)

(n) Pursuant to the provisions of N.J.S.A. 23:5-45.1c[, except in Delaware Bay and the Delaware River and tributaries,] the possession of one "trophy sized" striped bass, measuring not less than 38 inches in length, will be allowed in addition to the one fish allowed under the provision of N.J.S.A. 23:5-45.1(a) in accordance with the following provisions:

1.-5. (No change.)

6. Successful applicants shall keep **and submit annual** records of their [trophy fish] **striped bass** fishing activity as requested on forms furnished by the Division. Such records shall include, but not be limited to, the days and hours fished, number of striped bass caught [released] and location of fishing activity. **Extra forms can be obtained from fish checking stations.**

7.-13. (No change.)

(o) Any person violating the striped bass size or possession limits as provided for in N.J.S.A. 23:5-45.1, or (h) and (n) above shall be liable to a penalty of $100.00 per fish for the first offense and a penalty of $200.00 per fish for each subsquent offense. **In addition, any person violating any of (n) above shall be liable to revocation from the Striped Bass Trophy Fish Program. Any tag in such person's possession at that time shall be invalid and shall be returned to the Division upon notification of such revocation. Failure to return tag upon Division request shall subject the violator to penalties prescribed pursuant to N.J.S.A. 23:2B-14.**

(p)-(q) (No change.)

7:25-18.2 Pound Nets

(a) (No change.)

(b) General requirements for all pound net users are as follows:

1.-4. (No change.)

5. Any person operating any fish pound net in the marine waters of New Jersey, must, at the time of emptying the net, return to the waters wherein the net is located all [codfish less than ten inches in length, bluefish or weakfish less than nine inches in length, sea bass or kingfish less than eight inches in length, blackfish, mackerel and porgy less than seven inches in length, winter flounder less than six inches in length and summer flounder less than 14 inches in length. This paragraph does not apply to less than five percent by weight of the total catch of each species] **species less than the minimum size limits specified pursuant to N.J.A.C. 7:25-18.1.**

6.-8. (No change.)

(c) Specific requirements for pound net users in Raritan, [and] Sandy Hook **and Delaware** Bays are as follows:

1.-11. (No change.)

(d) (No change.)

(a)

ENVIRONMENTAL REGULATION—HAZARDOUS WASTE REGULATION ELEMENT

Notice of Intention to Hold an Informal Meeting to Confer and Consult with Members of the General Public, the Hazardous Waste Regulated Community, and Other Interested Persons Concerning Hazardous Waste Transportation Issues

Take notice that the New Jersey Department of Environmental Protection and Energy (the "Department") anticipates that it may propose amendments to N.J.A.C. 7:26-1.4, 4A.3, 5.4, 7.5 and 7.7 entitled "10 Day In-Transit Holding Rule" during 1994. To foster participation in the regulatory development process, the Department intends to informally confer and consult with members of the general public, the regulated community, and other interested persons. This meeting will take place in the Department's Public Hearing Room, 1st Floor, at 401 East State Street, Trenton, New Jersey on Wednesday, March 2, 1994 from 8:00 A.M. to 12:00 P.M.

Interested persons may obtain a current draft of the proposed "10 Day In-Transit Holding Rule" prior to the meeting by calling:

Bureau of Advisement & Manifest
(609) 292-8341

All correspondence and comments from the informal meeting will be considered in the further development of the "10 Day In-Transit Holding Rule."

HEALTH

(b)

DIVISION OF FAMILY HEALTH SERVICES

Chapter IV of State Sanitary Code

Operation of Clinical Laboratories; Reporting by Laboratory Supervisors

Proposed Amendment: N.J.A.C. 8:44-2.11

Authorized By: Public Health Council, William Frascella, O.D., Chairperson.

Authority: N.J.S.A. 26:1A-7, 24:14A-1 et seq, specifically 24:14A-11 and 26:2-130 et seq, specifically 26:2-137.

Proposal Number: PRN 1994-54.

A **public hearing** concerning this proposal will be held on Monday, February 14, 1994 at 1:00 P.M. at:

New Jersey Department of Health
Health & Agriculture Building
Auditorium
CN 360
Trenton, NJ 08625

Submit written comments by February 16, 1994 to:

Kevin McNally
Lead Poisoning Prevention Program
CN 364
Trenton, N.J. 08625

The agency proposal follows:

Summary

The Public Health Council proposes to amend N.J.A.C. 8:44-2.11, Reporting by laboratory supervisors, to make a distinction in the reporting of blood lead levels between children and adults, and to set a lower reporting level for blood lead levels in children. The Department of Health has recently proposed an amendment to this section changing the reporting levels for cadmium in blood and urine, and specifying the information required in laboratory reports. This proposed amendment addresses the separate issue of the reporting of elevated blood lead in children. It does not change or conflict with anything in the previous proposal.

The Department of Health is currently working on a major revision of Chapter IV for presentation to the Public Health Council within the next 18 months. However, this proposed amendment is a technical change that needs to go forward at this time, rather than wait until the entire chapter is revised, in order to bring the rule into congruence with recent changes in Federal policy related to lead poisoning in children.

These changes are required to make the rule consistent with similar reporting requirements contained in N.J.A.C. 8:51-6.1 and with the recommendations in the 1991 revision of the U.S. Centers for Disease Control and Prevention policy statement: "Preventing Lead Poisoning in Young Children."

Lead poisoning is one of the most common preventable childhood diseases in the United States today. It is a serious condition found mostly in children ages nine months through six years, caused by eating or breathing lead containing substances such as:

—lead-based paint, in the form of flaked paint chips or chewable surfaces in houses built before 1978;
—soil, dirt, and dust in which children play;
—tap water;
—food stored in lead soldered cans or improperly glazed pottery; and
—some folk remedies containing lead.

Chapter XIII of the New Jersey State Sanitary Code (N.J.A.C. 8:51) requires local health departments to screen children for lead poisoning, to follow-up children with elevated blood lead to insure they receive proper medical care, and to perform an environmental investigation on every reported case of a child with elevated blood lead to determine the source of the lead poisoning and to order the remediation of any lead hazards found. Chapter XIII includes a section (N.J.A.C. 8:51-6.1) requiring laboratories to report to the Department of Health the results of all elevated blood lead levels in children under six years of age.

New epidemiologic, clinical and environmental evidence has indicated that lead produces adverse health effects at levels previously thought to be non-toxic. The revised recommendations in the 1991 U.S. Centers for Disease Control and Prevention (CDC) policy statement, "Preventing Lead Poisoning In Young Children," reflect the current knowledge concerning screening, diagnosis, treatment, follow-up and environmental intervention for children with elevated blood lead levels. The 1991 policy statement recommends medical evaluation and environmental investigation for all children with blood lead levels greater than or equal to 20 ug/dL. As N.J.A.C. 8:51 incorporates the CDC policy statement, by reference, in its definition of "elevated blood lead," the laboratory reporting requirement in N.J.A.C. 8:51 automatically changed to greater than or equal to 20 ug/dL with the publication of the revised CDC policy statement. The proposed amendment is consistent with the revised CDC recommendations.

Currently, N.J.A.C. 8:44-2.11 requires laboratories to report to the State Department of Health all blood lead levels greater than or equal to 25 ug/dL. Prior to 1991, the CDC definition of elevated blood lead in children and the U.S. National Institute of Occupational Safety and Health (NIOSH) definition of elevated blood lead in adults were both greater than or equal to 25 ug/dL. While the 1991 CDC policy statement changed the definition of elevated blood lead in children under six years of age, the NIOSH definition of elevated blood lead in adults remains at 25 ug/dL. Therefore, the reporting rule now needs to distinguish between adults and children. For the purpose of this rule, the dividing line between children and adults is set at 16 years of age, the age at which a person is allowed to enter the workforce. While the CDC policy statement addresses only children under six years of age, similar concerns exist with regard to the exposure of older children to lead poisoning. Therefore, for the purposes of laboratory reporting, the Department proposes treating all children 16 years of age or younger in the same way.

Social Impact

Lead is a toxic heavy metal that is particularly damaging to the developing brain. Excessive absorption of lead is one of the most prevalent and preventable childhood health problems in the United States today. Lead metal and its oxides have been used for centuries in the manufacture of many items. It is a widely dispersed environmental hazard in New Jersey because of its extensive previous use in paint, gasoline, and plumbing, and its continuing use in industry. Lead, once absorbed, affects the blood, kidneys and nervous system. The effects on the nervous system are serious, the severity depending on the amount and length of lead exposure. They include learning disabilities, mental retardation and possible death. Children under six years of age are particularly susceptible to its toxic effects.

Recent research has indicated that even very small amounts of lead can have lasting toxic effects. This result influenced the U.S. Centers for Disease Control and Prevention to recommend that all children be screened for lead poisoning and to reduce the blood lead level at which public health intervention is recommended.

Children who have suffered from the adverse effects of lead are frequently in need of special health and educational services in order to assist them to develop to their potential as productive members of society.

Because lead is present throughout the environment in New Jersey, all children in the state are at risk. The well being of these children is dependent on early detection followed by prompt medical and environmental intervention. The proposed amendment will update the rule to be consistent with the latest recommendations from the U.S. Centers for Disease Control and Prevention. It will insure prompt notification to the Department of Health of all children with elevated blood lead. The Department of Health will, in turn, notify the local health department in whose jurisdiction the child resides, which will insure the implementation of the strategies necessary to reduce these serious health consequences.

Economic Impact

In that laboratories are already required to report elevated blood lead results to the Department of Health, the costs to laboratories of implementing this amendment will be minimal. It's estimated that the number of children reported by laboratories to the Department of Health would increase by 50 percent. However, as most laboratories use computerized data recording and reporting systems, the only cost to the laboratory would be to change the reporting threshold in the computer program.

Economic benefits of identifying children with elevated blood lead and removing the source of exposure are considerable for the child, the family, and society. The U.S. Centers for Disease Control and Prevention estimates that prevention of lead poisoning results in a savings of $1,300 in medical costs and $3,331 in special education costs per child. It is estimated that approximately 3,000 children each year will be identified with blood lead greater than or equal to 20 ug/dL. The potential economic cost of lead poisoning in these children, if they are not identified and prompt intervention initiated, is approximately $14 million a year.

Regulatory Flexibility Analysis

The proposed amendment would effect 15 laboratories that are currently licensed to perform blood lead tests. Of these, it is estimated that eight (53 percent) could be considered small businesses, as the term is defined in N.J.S.A. 52:14B-16 et seq. All of these laboratories are already required to report elevated blood lead test results to the Department of Health. This amendment changes only the blood lead level at which a report is required. The costs of compliance will be different for each laboratory, but are expected to be minimal. There would be a one-time cost of changing the computer program for reporting. There may be

additional on-going costs associated with the mailing of additional reports to the Department of Health. However, the Department feels that the benefit to society and the potential savings associated with identification of, and prompt intervention with, children with elevated blood lead far outweigh this minimal expense to the small businesses. Therefore, no differentiation based on business size has been provided in the rule.

Full text of the proposed amendment follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

8:44-2.11 Reporting by laboratory supervisors

(a) (No change.)

(b) Laboratory supervisors shall immediately report to the State Department of Health, results of laboratory examinations indicating levels of hazardous substances in blood and urine equal to or greater than the following:

1. Lead:

i. Blood lead levels equal to or greater than 25 ug/dL **in individuals greater than 16 years of age;**

ii. Blood lead levels equal to or greater than 20 ug/dL in children up to and including 16 years of age;

[ii.]**iii.** Urine lead levels equal to or greater than 80 ug/dL in individuals greater than 16 years of age.

2.-4. (No change.)

(c) (No change.)

HUMAN SERVICES

(a)

DIVISION OF FAMILY DEVELOPMENT

Child Care Services Manual
Public Assistance Manual
Assistance Standards Handbook
Family Development Program Manual
Child Care Payment Rates/Age Categories; Co-payment for Child Care

Proposed Amendments: N.J.A.C. 10:15A-1.2; 10:15C-1.1; 10:81-14.18A; 10:82-5.3; and 10:86-10.2 and 10.6

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:1-12 and 44:10-3.

Proposal Number: PRN 1994-45.

Submit comments by February 17, 1994 to:

Marion E. Reitz, Director
Division of Family Development
CN 716
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendments increase and align child care payment rates and co-payment fees in the various Departmental child care service programs supervised by the Division of Family Development (DFD), in order to support a continuum of child care services for families in various stages of need through "seamless services" to recipients and providers. The proposed amendments deal with the Aid to Families with Dependent Children (AFDC) JOBS Child Care Program, the Transitional Child Care Program (TCC), and the Title IV-A At-Risk Child Care (ARCC) and Child Care and Development Block Grant (CCDBG) programs, which New Jersey incorporated into one Statewide child care voucher program, the New Jersey Cares for Kids (NJCK) Child Care Certificate Program, in January 1992.

Both programs, IV-A At-Risk and CCDBG, were authorized under the Federal Omnibus Budget Reconciliation Act (OBRA) of 1990 (Public Law 101-508). The objective of the IV-A ARCC program is to provide child care to low-income families who need child care in order to accept or maintain employment, who are not currently AFDC recipients, but who are at risk of becoming AFDC eligible. The purpose of the CCDBG program is to increase the availability, affordability and quality of child care for low-income families with a parent who is working or attending a training or educational program.

The proposed amendments at N.J.A.C. 10:15A-1.2(c) (Tables I, II and III) reflect revised maximum allowable child care payment rates for the NJCK Certificate Program. Included in the proposed amendments, for alignment with the NJCK program, the child care payment rates at N.J.A.C. 10:82-5.3(g)5 Tables I, II and III are also revised for JOBS and Title IV-A child care support services, and at N.J.A.C. 10:86-10.2(d) for the Family Development Program (FDP) child care support services; thus, allowing for continuity among the programs.

The adjustment of the child care rates is a result of a three percent Cost-of-Living Adjustment (COLA) for center based child care providers, under contract with DHS through its Division of Youth and Family Services (DYFS). The aforementioned factor affects child care services provided through both the Divisions (that is, DFD and DYFS) and, therefore, in order to maintain a seamless system, adjustments must occur in all DHS child care components.

Each family receiving child care is required to contribute a co-payment toward the cost of such care. The exception to the co-payment requirement applies to protective services child(ren) as identified by DYFS (see N.J.A.C. 10:15-1.2). Additionally, no co-payment is required for purposes of other child care programs if the family has children in care through the CCDBG or IV-A At-Risk programs and the family is making a co-payment for two children under either of these child care program requirements. The co-payment scales are aligned at N.J.A.C. 10:15C-1.1(d), 10:81-14.18A(d) and 10:86-10.6(b) to reflect a change in income levels. The proposed amendment to the co-payment scales will allow all individuals who are participating in CCDBG job or educational training, who have zero income, to be assessed a zero co-payment.

Social Impact

The child care rate increases are due to an alignment of child care rates with those of the Department's DYFS child care program. Since DYFS was appropriated a cost-of-living adjustment for child care, DFD, due to the seamless child care system, has commensurately increased rates in the child care programs it supervises. The increases, though slight, reflect the Department's intention to help families as much as possible with any available State resources. The increase will make a broader number of providers accessible to parents participating in DFD's subsidized child care programs.

The co-payment scales enable the State to continue subsidizing child care services when families are most in need and mandate, per Federal requirements in the three child care components, a parental contribution toward the cost of that care. The proposed amendment will eliminate the co-payment for those families having no income who are participating in CCDBG job or educational training. Thus, a small savings to the client will be realized.

Economic Impact

The proposed co-payment amendment will eliminate the co-payment for those families having zero income who are participating in CCDBG job or educational training. Thus, a small savings to the client will be realized. There will be no economic impact to the State, since the payments are funded 100 percent by the Federal government.

The increases in child care rate costs represent a two percent increase applicable to licensed centers, registered and approved home arrangements. Any increase, however small, makes a larger number of providers accessible.

Regulatory Flexibility Statement

Child care providers eligible to receive parent certificates for child care services through these programs will not be affected. While some of these providers can be categorized as small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., no additional professional services or costs will be needed to comply with the provisions of these rules. The amendments affect individuals who utilize the child care services of these providers.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10:15A-1.2 Payment policies

(a)-(b) (No change.)

(c) The maximum child care payment rates are set forth in Tables I, II and III below. The maximum child care payment rates utilized in the Department of Human Services child care service programs

are available through a written request to the New Jersey Department of Human Services, Division of Family Development, CN 716, Trenton, NJ 08625, or the local Division of Youth and Family Services Regional Office, the county welfare agency or the county designated agency.

1.-3. (No change.)

4. Tables I, II and III specify monthly, weekly and daily rates for the various age categories of children based on the hours of care provided.

[NJCK CHILD CARE CERTIFICATE/VOUCHER MAXIMUM RATES

Table I

These rates shall be utilized for:

LICENSED CHILD CARE CENTERS, SCHOOL-AGE PROGRAMS, SUMMER DAY CAMPS

	Hours of Care Provided	
Child's Service Category	Full Time 6 hrs. or more/day	Part-Time Less than 6 hrs./day
Infants/Toddlers (0 up to 2 yrs.)		
Monthly	$503.15	$251.58
Weekly	$116.20	$ 58.10
Daily Equivalent	$ 23.24	$ 11.62
Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	$503.15	$251.58
Weekly	$116.20	$ 58.10
Daily Equivalent	$ 23.24	$ 11.62
Pre-Schoolers (2.5 up to 5 yrs.)		
Monthly	$414.82	$207.41
Weekly	$ 95.80	$ 47.90
Daily Equivalent	$ 19.16	$ 9.58
Kindergartner & School-Agers (5-13 yrs.)		
Monthly	$414.82	$207.41
Weekly	$ 95.80	$ 47.90
Daily Equivalent	$ 19.16	$ 9.58
Special Needs Infants/Toddlers (0 up to 2 yrs.)		
Monthly	$503.15	$251.58
Weekly	$116.20	$ 58.10
Daily Equivalent	$ 23.24	$ 11.62
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	$503.15	$251.58
Weekly	$116.20	$ 58.10
Daily Equivalent	$ 23.24	$ 11.62
Special Needs (2.5 up to 19 yrs.)		
Monthly	$414.82	$207.41
Weekly	$ 95.80	$ 47.90
Daily Equivalent	$ 19.16	$ 9.58

The above represents the maximum authorized rates for child care. The NJCK Child Care Certificate Program may authorize payment for the actual cost of care up to these amounts. The required co-payment will be deducted from the appropriate rate before voucher payment is issued. Parent/applicant may select child care with a cost higher than these maximum rates; however, in such instances the parent/applicant is totally responsible for all expenses in excess of these authorized maximum rates as well as for the required co-payment.]

[NJCK CHILD CARE CERTIFICATE/VOUCHER MAXIMUM RATES

Table II

These rates shall be utilized for:

REGISTERED FAMILY DAY CARE HOMES

	Hours of Care Provided	
Child's Service Category	Full Time 6 hrs. or more/day	Part-Time Less than 6 hrs./day
Infants/Toddlers (0 up to 2 yrs.)		
Monthly	$397.50	$198.75
Weekly	$ 91.80	$ 45.90
Daily Equivalent	$ 18.36	$ 9.18
Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	$397.50	$198.75
Weekly	$ 91.80	$ 45.90
Daily Equivalent	$ 18.36	$ 9.18
Pre-Schoolers (2.5 up to 5 yrs.)		
Monthly	$309.17	$154.59
Weekly	$ 71.40	$ 35.70
Daily Equivalent	$ 14.28	$ 7.14
Kindergartner & School-Agers (5-13 yrs.)		
Monthly	$309.17	$154.59
Weekly	$ 71.40	$ 35.70
Daily Equivalent	$ 14.28	$ 7.14
Special Needs Infants/Toddlers (0 up to 2 yrs.)		
Monthly	$485.83	$242.92
Weekly	$112.20	$ 56.10
Daily Equivalent	$ 22.44	$ 11.22
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	$485.83	$242.92
Weekly	$112.20	$ 56.10
Daily Equivalent	$ 22.44	$ 11.22
Special Needs (2.5 up to 19 yrs.)		
Monthly	$397.50	$198.75
Weekly	$ 91.80	$ 45.90
Daily Equivalent	$ 18.36	$ 9.18

The above represents the maximum authorized rates for child care. The NJCK Child Care Certificate Program may authorize payment for the actual cost of care up to these amounts. The required co-payment will be deducted from the appropriate rate before voucher payment is issued. Parent/applicant may select child care with a cost higher than these maximum rates; however, in such instances the parent/applicant is totally responsible for all expenses in excess of these authorized maximum rates as well as for the required co-payment.]

[NJCK CHILD CARE CERTIFICATE/VOUCHER MAXIMUM RATES

Table III

These rates shall be utilized for:

APPROVED HOME DAY CARE

Child's Service Category	Hours of Care Provided: Full Time 6 hrs. or more/day	Part-Time Less than 6 hrs./day
Infants/Toddlers (0 up to 2 yrs.)		
Monthly	$238.58	$119.29
Weekly	$ 55.10	$ 27.55
Daily Equivalent	$ 11.02	$ 5.51
Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	$238.58	$119.29
Weekly	$ 55.10	$ 27.55
Daily Equivalent	$ 11.02	$ 5.51
Pre-Schoolers (2.5 up to 5 yrs.)		
Monthly	$185.32	$ 92.66
Weekly	$ 42.80	$ 21.40
Daily Equivalent	$ 8.56	$ 4.28
Kindergartner & School-Agers (5-13 yrs.)		
Monthly	$185.32	$ 92.66
Weekly	$ 42.80	$ 21.40
Daily Equivalent	$ 8.56	$ 4.28
Special Needs Infants/Toddlers (0 up to 2 yrs.)		
Monthly	$291.40	$145.70
Weekly	$ 67.30	$ 33.65
Daily Equivalent	$ 13.46	$ 6.73
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	$291.40	$145.70
Weekly	$ 67.30	$ 33.65
Daily Equivalent	$ 13.46	$ 6.73
Special Needs (2.5 up to 19 yrs.)		
Monthly	$238.58	$119.29
Weekly	$ 55.10	$ 27.55
Daily Equivalent	$ 11.02	$ 5.51

The above represents the maximum authorized rates for child care. The NJCK Child Care Certificate Program may authorize payment for the actual cost of care up to these amounts. The required co-payment will be deducted from the appropriate rate before voucher payment is issued. Parent/applicant may select child care with a cost higher than these maximum rates; however, in such instances the parent/applicant is totally responsible for all expenses in excess of these authorized maximum rates as well as for the required co-payment.]

NJCK CHILD CARE CERTIFICATE/VOUCHER MAXIMUM RATES

Table I

These rates shall be utilized for:

LICENSED CHILD CARE CENTERS, SCHOOL-AGE PROGRAMS, SUMMER DAY CAMPS

Child's Service Category	Hours of Care Provided: Full Time 6 hrs. or more/day	Part-Time Less than 6 hrs./day
Infants/Toddlers (0 up to 2 yrs.)		
Monthly	**$513.12**	**$256.56**
Weekly	**$118.50**	**$ 59.25**
Daily Equivalent	**$ 23.70**	**$ 11.85**
Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	**$513.12**	**$256.56**
Weekly	**$118.50**	**$ 59.25**
Daily Equivalent	**$ 23.70**	**$ 11.85**
Pre-Schoolers (2.5 up to 5 yrs.)		
Monthly	**$423.04**	**$211.52**
Weekly	**$ 97.70**	**$ 48.85**
Daily Equivalent	**$ 19.54**	**$ 9.77**
Kindergartener & School-Agers (5-13 yrs.)		
Monthly	**$423.04**	**$211.52**
Weekly	**$ 97.70**	**$ 48.85**
Daily Equivalent	**$ 19.54**	**$ 9.77**
Special Needs Infants/Toddlers (0 up to 2 yrs.)		
Monthly	**$513.12**	**$256.56**
Weekly	**$118.50**	**$ 59.25**
Daily Equivalent	**$ 23.70**	**$ 11.85**
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	**$513.12**	**$256.56**
Weekly	**$118.50**	**$ 59.25**
Daily Equivalent	**$ 23.70**	**$ 11.85**
Special Needs (2.5 up to 19 yrs.)		
Monthly	**$423.04**	**$211.52**
Weekly	**$ 97.70**	**$ 48.85**
Daily Equivalent	**$ 19.54**	**$ 9.77**

The above represents the maximum authorized rates for child care. The NJCK Child Care Certificate Program may authorize payment for the actual cost of care up to these amounts. The required co-payment will be deducted from the appropriate rate before voucher payment is issued. Parent/applicant may select child care with a cost higher than these maximum rates; however, in such instances the parent/applicant is totally responsible for all expenses in excess of these authorized maximum rates as well as for the required co-payment.

NJCK CHILD CARE CERTIFICATE/VOUCHER
MAXIMUM RATES

Table II

These rates shall be utilized for:

REGISTERED FAMILY DAY CARE HOMES

Child's Service Category	Hours of Care Provided: Full Time 6 hrs. or more/day	Part-Time Less than 6 hrs./day
Infants/Toddlers (0 up to 2 yrs.)		
Monthly	$405.30	$202.65
Weekly	$ 93.60	$ 46.80
Daily Equivalent	$ 18.72	$ 9.36
Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	$405.30	$202.65
Weekly	$ 93.60	$ 46.80
Daily Equivalent	$ 18.72	$ 9.36
Pre-Schoolers (2.5 up to 5 yrs.)		
Monthly	$317.40	$158.70
Weekly	$ 73.30	$ 36.65
Daily Equivalent	$ 14.66	$ 7.33
Kindergartener & School-Agers (5-13 yrs.)		
Monthly	$317.40	$158.70
Weekly	$ 73.30	$ 36.65
Daily Equivalent	$ 14.66	$ 7.33
Special Needs Infants/Toddlers (0 up to 2 yrs.)		
Monthly	$493.62	$246.81
Weekly	$114.00	$ 57.00
Daily Equivalent	$ 22.80	$ 11.40
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	$493.62	$246.81
Weekly	$114.00	$ 57.00
Daily Equivalent	$ 22.80	$ 11.40
Special Needs (2.5 up to 19 yrs.)		
Monthly	$405.30	$202.65
Weekly	$ 93.60	$ 46.80
Daily Equivalent	$ 18.72	$ 9.36

The above represents the maximum authorized rates for child care. The NJCK Child Care Certificate Program may authorize payment for the actual cost of care up to these amounts. The required co-payment will be deducted from the appropriate rate before voucher payment is issued. Parent/applicant may select child care with a cost higher than these maximum rates; however, in such instances the parent/applicant is totally responsible for all expenses in excess of these authorized maximum rates as well as for the required co-payment.

NJCK CHILD CARE CERTIFICATE/VOUCHER
MAXIMUM RATES

Table III

These rates shall be utilized for:

APPROVED HOME DAY CARE

Child's Service Category	Hours of Care Provided: Full Time 6 hrs. or more/day	Part-Time Less than 6 hrs./day
Infants/Toddlers (0 up to 2 yrs.)		
Monthly	$243.36	$121.68
Weekly	$ 56.20	$ 28.10
Daily Equivalent	$ 11.24	$ 5.62
Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	$243.36	$121.68
Weekly	$ 56.20	$ 28.10
Daily Equivalent	$ 11.24	$ 5.62
Pre-Schoolers (2.5 up to 5 yrs.)		
Monthly	$190.52	$ 95.26
Weekly	$ 44.00	$ 22.00
Daily Equivalent	$ 8.80	$ 4.40
Kindergartener & School-Agers (5-13 yrs.)		
Monthly	$190.52	$ 95.26
Weekly	$ 44.00	$ 22.00
Daily Equivalent	$ 8.80	$ 4.40
Special Needs Infants/Toddlers (0 up to 2 yrs.)		
Monthly	$296.18	$148.09
Weekly	$ 68.40	$ 34.20
Daily Equivalent	$ 13.68	$ 6.84
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)		
Monthly	$296.18	$148.09
Weekly	$ 68.40	$ 34.20
Daily Equivalent	$ 13.68	$ 6.84
Special Needs (2.5 up to 19 yrs.)		
Monthly	$243.36	$121.68
Weekly	$ 56.20	$ 28.10
Daily Equivalent	$ 11.24	$ 5.62

The above represents the maximum authorized rates for child care. The NJCK Child Care Certificate Program may authorize payment for the actual cost of care up to these amounts. The required co-payment will be deducted from the appropriate rate before voucher payment is issued. Parent/applicant may select child care with a cost higher than these maximum rates; however, in such instances the parent/applicant is totally responsible for all expenses in excess of these authorized maximum rates as well as for the required co-payment.

(d)-(g) (No change.)

10:15C-1.1 Co-payment procedures

(a)-(c) (No change.)

(d) The amount of the required co-payment is based on the family's annual gross income level, family size, number of children, and number of children in care. Assessed co-payments are apportioned weekly and are due for the entire period of time that subsidized child care assistance is received. Holidays, emergency closings, and absences do not exclude or reduce the required co-payment. There are two co-payment scales:

[Table I
CHILD CARE CO-PAYMENT SCALE
FULL TIME CARE†

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment††		Percent of State 1989	Family Size and Annual Income††††				
First Child	Second Child†††	First Child	Second Child†††	Median Family Income	2	3	4	5	6
$1.10	$0.55	$4.76	$2.38	0% - 5%	0 - 1,768	0 - 2,184	0 - 2,600	0 - 3,016	0 - 3,432
$4.40	$2.20	$19.05	$9.53	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$6.60	$3.30	$28.58	$14.29	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$9.90	$4.95	$42.87	$21.43	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$12.10	$6.05	$52.39	$26.20	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$15.40	$7.70	$66.68	$33.34	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$19.80	$9.90	$85.73	$42.87	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$24.20	$12.10	$104.79	$52.39	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$29.70	$14.85	$128.60	$64.30	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$35.20	$17.60	$152.42	$76.21	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$40.70	$20.35	$176.23	$88.12	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$47.30	$23.65	$204.81	$102.40	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$55.00	$27.50	$238.15	$119.08	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$62.70	$31.35	$271.49	$135.75	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$67.10	$33.55	$290.54	$145.27	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment††		Percent of State 1989	Family Size and Annual Income					
First Child	Second Child†††	First Child	Second Child†††	Median Family Income	7	8	9	10	11	12
$1.10	$0.55	$4.76	$2.38	0% - 5%	0 - 3,510	0 - 3,588	0 - 3,666	0 - 3,744	0 - 3,822	0 - 3,900
$4.40	$2.20	$19.05	$9.53	5% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$6.60	$3.30	$28.58	$14.29	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$9.90	$4.95	$42.87	$21.43	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$12.10	$6.05	$52.39	$26.20	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$15.40	$7.70	$66.68	$33.34	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$19.80	$9.90	$85.73	$42.87	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$24.20	$12.10	$104.79	$52.39	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$29.70	$14.85	$128.60	$64.30	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$35.20	$17.60	$152.42	$76.21	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$40.70	$20.35	$176.23	$88.12	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$47.30	$23.65	$204.81	$102.40	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$55.00	$27.50	$238.15	$119.08	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$62.70	$31.35	$271.49	$135.75	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$67.10	$33.55	$290.54	$145.27	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

†Full time care is defined as six (6) or more hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $1.00 ($2.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.]

[Table II
CHILD CARE CO-PAYMENT SCALE
PART-TIME CARE†

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment††		Percent of State 1989	Family Size and Annual Income††††				
First Child	Second Child†††	First Child	Second Child†††	Median Family Income	2	3	4	5	6
$0.00	$0.00	$0.00	$0.00	0% - 5%	0 - 1,768	0 - 2,184	0 - 2,600	0 - 3,016	0 - 3,432
$2.20	$1.10	$9.53	$4.76	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$3.30	$1.65	$14.29	$7.14	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$4.40	$2.20	$19.05	$9.53	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$5.50	$2.75	$23.82	$11.91	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$7.70	$3.85	$33.34	$16.67	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$9.90	$4.95	$42.87	$21.43	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$12.10	$6.05	$52.39	$26.20	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$14.30	$7.15	$61.92	$30.96	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$17.60	$8.80	$76.21	$38.10	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$19.80	$9.90	$85.73	$42.87	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$23.10	$11.55	$100.02	$50.01	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$27.50	$13.75	$119.08	$59.54	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$30.80	$15.40	$133.36	$66.68	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$33.00	$16.50	$142.89	$71.45	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment††		Percent of State 1989	Family Size and Annual Income					
First Child	Second Child†††	First Child	Second Child†††	Median Family Income	7	8	9	10	11	12
$0.00	$0.00	$0.00	$0.00	0% - 5%	0 - 3,510	0 - 3,588	0 - 3,666	0 - 3,744	0 - 3,822	0 - 3,900
$2.20	$1.10	$9.53	$4.76	5% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$3.30	$1.65	$14.29	$7.14	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$4.40	$2.20	$19.05	$9.53	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$5.50	$2.75	$23.82	$11.91	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$7.70	$3.85	$33.34	$16.67	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$9.90	$4.95	$42.87	$21.43	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$12.10	$6.05	$52.39	$26.20	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$14.30	$7.15	$61.92	$30.96	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$17.60	$8.80	$76.21	$38.10	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$19.80	$9.90	$85.73	$42.87	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$23.10	$11.55	$100.02	$50.01	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$27.50	$13.75	$119.08	$59.54	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$30.80	$15.40	$133.36	$66.68	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$33.00	$16.50	$142.89	$71.45	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

†Part-time care is defined as less than six (6) hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $.50 ($1.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.]

Table I
CHILD CARE CO-PAYMENT SCHEDULE
FULL TIME CARE*

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment**		Percent of State 1989	Family Size and Annual Income				
First Child	Second Child***	First Child	Second Child***	Median Family Income	1 or 2	3	4	5	6
$0	$0	$0	$0	0%	0	0	0	0	0
$1.10	$0.55	$4.76	$2.38	1% - 5%	1 - 1,768	1 - 2,184	1 - 2,600	1 - 3,016	1 - 3,432
$4.40	$2.20	$19.05	$9.53	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$6.60	$3.30	$28.58	$14.29	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$9.90	$4.95	$42.87	$21.43	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$12.10	$6.05	$52.39	$26.20	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$15.40	$7.70	$66.68	$33.34	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$19.80	$9.90	$85.73	$42.87	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$24.20	$12.10	$104.79	$52.39	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$29.70	$14.85	$128.60	$64.30	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$35.20	$17.60	$152.42	$76.21	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$40.70	$20.35	$176.23	$88.12	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$47.30	$23.65	$204.81	$102.40	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$55.00	$27.50	$238.15	$119.08	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$62.70	$31.35	$271.49	$135.75	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$67.10	$33.55	$290.54	$145.27	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment**		Percent of State 1989	Family Size and Annual Income					
First Child	Second Child***	First Child	Second Child***	Median Family Income	7	8	9	10	11	12
$0	$0	$0	$0	0%	0	0	0	0	0	0
$1.10	$0.55	$4.76	$2.38	1% - 5%	1 - 3,510	1 - 3,588	1 - 3,666	1 - 3,744	1 - 3,822	1 - 3,900
$4.40	$2.20	$19.05	$9.53	6% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$6.60	$3.30	$28.58	$14.29	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$9.90	$4.95	$42.87	$21.43	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$12.10	$6.05	$52.39	$26.20	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$15.40	$7.70	$66.68	$33.34	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$19.80	$9.90	$85.73	$42.87	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$24.20	$12.10	$104.79	$52.39	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$29.70	$14.85	$128.60	$64.30	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$35.20	$17.60	$152.42	$76.21	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$40.70	$20.35	$176.23	$88.12	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$47.30	$23.65	$204.81	$102.40	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$55.00	$27.50	$238.15	$119.08	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$62.70	$31.35	$271.49	$135.75	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$67.10	$33.55	$290.54	$145.27	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

*Full time care is defined as six (6) or more hours of care per day.

**The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

***The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

Table II
CHILD CARE CO-PAYMENT SCHEDULE
PART-TIME CARE*

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment**		Percent of State 1989	Family Size and Annual Income				
First Child	Second Child***	First Child	Second Child***	Median Family Income	1 or 2	3	4	5	6
$0	$0	$0	$0	0%	0	0	0	0	0
$0.00	$0.00	$0.00	$0.00	1% - 5%	1 - 1,768	1 - 2,184	1 - 2,600	1 - 3,016	1 - 3,432
$2.20	$1.10	$9.53	$4.76	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$3.30	$1.65	$14.29	$7.14	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$4.40	$2.20	$19.05	$9.53	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$5.50	$2.75	$23.82	$11.91	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$7.70	$3.85	$33.34	$16.67	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$9.90	$4.95	$42.87	$21.43	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$12.10	$6.05	$52.39	$26.20	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$14.30	$7.15	$61.92	$30.96	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$17.60	$8.80	$76.21	$38.10	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$19.80	$9.90	$85.73	$42.87	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$23.10	$11.55	$100.02	$50.01	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$27.50	$13.75	$119.08	$59.54	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$30.80	$15.40	$133.36	$66.68	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$33.00	$16.50	$142.89	$71.45	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment**		Percent of State 1989	Family Size and Annual Income					
First Child	Second Child***	First Child	Second Child***	Median Family Income	7	8	9	10	11	12
$0	$0	$0	$0	0%	0	0	0	0	0	0
$0.00	$0.00	$0.00	$0.00	1% - 5%	1 - 3,510	1 - 3,588	1 - 3,666	1 - 3,744	1 - 3,822	1 - 3,900
$2.20	$1.10	$9.53	$4.76	6% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$3.30	$1.65	$14.29	$7.14	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$4.40	$2.20	$19.05	$9.53	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$5.50	$2.75	$23.82	$11.91	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$7.70	$3.85	$33.34	$16.67	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$9.90	$4.95	$42.87	$21.43	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$12.10	$6.05	$52.39	$26.20	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$14.30	$7.15	$61.92	$30.96	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$17.60	$8.80	$76.21	$38.10	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$19.80	$9.90	$85.73	$42.87	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$23.10	$11.55	$100.02	$50.01	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$27.50	$13.75	$119.08	$59.54	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$30.80	$15.40	$133.36	$66.68	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$33.00	$16.50	$142.89	$71.45	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

*Part-time care is defined as less than six (6) hours of care per day.

**The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

***The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

(e)-(g) (No change.)

10:81-14.18A REACH post-AFDC co-payment scale

(a)-(c) (No change.)

(d) The co-payment scales are as follows:

1. (No change.)

2. Assessed co-payments are apportioned weekly and are due for the entire 52-week period that subsidized child care assistance is received. Holidays, emergency closings, and absences do not exclude or reduce the required fee co-payment.

[Table I
CHILD CARE CO-PAYMENT SCALE
FULL TIME CARE†

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment††		Percent of State 1989 Median Family Income	Family Size and Annual Income††††				
First Child	Second Child†††	First Child	Second Child†††		2	3	4	5	6
$1.10	$0.55	$4.76	$2.38	0% - 5%	0 - 1,768	0 - 2,184	0 - 2,600	0 - 3,016	0 - 3,432
$4.40	$2.20	$19.05	$9.53	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$6.60	$3.30	$28.58	$14.29	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$9.90	$4.95	$42.87	$21.43	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$12.10	$6.05	$52.39	$26.20	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$15.40	$7.70	$66.68	$33.34	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$19.80	$9.90	$85.73	$42.87	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$24.20	$12.10	$104.79	$52.39	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$29.70	$14.85	$128.60	$64.30	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$35.20	$17.60	$152.42	$76.21	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$40.70	$20.35	$176.23	$88.12	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$47.30	$23.65	$204.81	$102.40	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$55.00	$27.50	$238.15	$119.08	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$62.70	$31.35	$271.49	$135.75	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$67.10	$33.55	$290.54	$145.27	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment††		Percent of State 1989 Median Family Income	Family Size and Annual Income					
First Child	Second Child†††	First Child	Second Child†††		7	8	9	10	11	12
$1.10	$0.55	$4.76	$2.38	0% - 5%	0 - 3,510	0 - 3,588	0 - 3,666	0 - 3,744	0 - 3,822	0 - 3,900
$4.40	$2.20	$19.05	$9.53	5% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$6.60	$3.30	$28.58	$14.29	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$9.90	$4.95	$42.87	$21.43	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$12.10	$6.05	$52.39	$26.20	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$15.40	$7.70	$66.68	$33.34	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$19.80	$9.90	$85.73	$42.87	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$24.20	$12.10	$104.79	$52.39	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$29.70	$14.85	$128.60	$64.30	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$35.20	$17.60	$152.42	$76.21	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$40.70	$20.35	$176.23	$88.12	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$47.30	$23.65	$204.81	$102.40	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$55.00	$27.50	$238.15	$119.08	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$62.70	$31.35	$271.49	$135.75	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$67.10	$33.55	$290.54	$145.27	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

†Full time care is defined as six (6) or more hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $1.00 ($2.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.]

[Table II
CHILD CARE CO-PAYMENT SCALE
PART-TIME CARE†

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment††		Percent of State 1989	Family Size and Annual Income††††				
First Child	Second Child†††	First Child	Second Child†††	Median Family Income	2	3	4	5	6
$0.00	$0.00	$0.00	$0.00	0% - 5%	0 - 1,768	0 - 2,184	0 - 2,600	0 - 3,016	0 - 3,432
$2.20	$1.10	$9.53	$4.76	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$3.30	$1.65	$14.29	$7.14	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$4.40	$2.20	$19.05	$9.53	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$5.50	$2.75	$23.82	$11.91	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$7.70	$3.85	$33.34	$16.67	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$9.90	$4.95	$42.87	$21.43	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$12.10	$6.05	$52.39	$26.20	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$14.30	$7.15	$61.92	$30.96	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$17.60	$8.80	$76.21	$38.10	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$19.80	$9.90	$85.73	$42.87	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$23.10	$11.55	$100.02	$50.01	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$27.50	$13.75	$119.08	$59.54	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$30.80	$15.40	$133.36	$66.68	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$33.00	$16.50	$142.89	$71.45	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment††		Percent of State 1989	Family Size and Annual Income					
First Child	Second Child†††	First Child	Second Child†††	Median Family Income	7	8	9	10	11	12
$0.00	$0.00	$0.00	$0.00	0% - 5%	0 - 3,510	0 - 3,588	0 - 3,666	0 - 3,744	0 - 3,822	0 - 3,900
$2.20	$1.10	$9.53	$4.76	5% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$3.30	$1.65	$14.29	$7.14	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$4.40	$2.20	$19.05	$9.53	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$5.50	$2.75	$23.82	$11.91	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$7.70	$3.85	$33.34	$16.67	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$9.90	$4.95	$42.87	$21.43	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$12.10	$6.05	$52.39	$26.20	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$14.30	$7.15	$61.92	$30.96	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$17.60	$8.80	$76.21	$38.10	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$19.80	$9.90	$85.73	$42.87	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$23.10	$11.55	$100.02	$50.01	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$27.50	$13.75	$119.08	$59.54	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$30.80	$15.40	$133.36	$66.68	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$33.00	$16.50	$142.89	$71.45	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

†Part-time care is defined as less than six (6) hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $.50 ($1.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.]

Table I
CHILD CARE CO-PAYMENT SCHEDULE
FULL TIME CARE*

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment**		Percent of State 1989	Family Size and Annual Income				
First Child	Second Child***	First Child	Second Child***	Median Family Income	1 or 2	3	4	5	6
$0	$0	$0	$0	0%	0	0	0	0	0
$1.10	$0.55	$4.76	$2.38	1% - 5%	1 - 1,768	1 - 2,184	1 - 2,600	1 - 3,016	1 - 3,432
$4.40	$2.20	$19.05	$9.53	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$6.60	$3.30	$28.58	$14.29	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$9.90	$4.95	$42.87	$21.43	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$12.10	$6.05	$52.39	$26.20	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$15.40	$7.70	$66.68	$33.34	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$19.80	$9.90	$85.73	$42.87	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$24.20	$12.10	$104.79	$52.39	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$29.70	$14.85	$128.60	$64.30	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$35.20	$17.60	$152.42	$76.21	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$40.70	$20.35	$176.23	$88.12	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$47.30	$23.65	$204.81	$102.40	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$55.00	$27.50	$238.15	$119.08	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$62.70	$31.35	$271.49	$135.75	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$67.10	$33.55	$290.54	$145.27	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment**		Percent of State 1989	Family Size and Annual Income					
First Child	Second Child***	First Child	Second Child***	Median Family Income	7	8	9	10	11	12
$0	$0	$0	$0	0%	0	0	0	0	0	0
$1.10	$0.55	$4.76	$2.38	1% - 5%	1 - 3,510	1 - 3,588	1 - 3,666	1 - 3,744	1 - 3,822	1 - 3,900
$4.40	$2.20	$19.05	$9.53	6% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$6.60	$3.30	$28.58	$14.29	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$9.90	$4.95	$42.87	$21.43	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$12.10	$6.05	$52.39	$26.20	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$15.40	$7.70	$66.68	$33.34	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$19.80	$9.90	$85.73	$42.87	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$24.20	$12.10	$104.79	$52.39	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$29.70	$14.85	$128.60	$64.30	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$35.20	$17.60	$152.42	$76.21	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$40.70	$20.35	$176.23	$88.12	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$47.30	$23.65	$204.81	$102.40	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$55.00	$27.50	$238.15	$119.08	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$62.70	$31.35	$271.49	$135.75	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$67.10	$33.55	$290.54	$145.27	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

*Full time care is defined as six (6) or more hours of care per day.

**The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

***The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

Table II
CHILD CARE CO-PAYMENT SCHEDULE
PART-TIME CARE*

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment**		Percent of State 1989	Family Size and Annual Income				
First Child	Second Child***	First Child	Second Child***	Median Family Income	1 or 2	3	4	5	6
$0	$0	$0	$0	0%	0	0	0	0	0
$0.00	$0.00	$0.00	$0.00	1% - 5%	1 - 1,768	1 - 2,184	1 - 2,600	1 - 3,016	1 - 3,432
$2.20	$1.10	$9.53	$4.76	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$3.30	$1.65	$14.29	$7.14	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$4.40	$2.20	$19.05	$9.53	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$5.50	$2.75	$23.82	$11.91	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$7.70	$3.85	$33.34	$16.67	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$9.90	$4.95	$42.87	$21.43	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$12.10	$6.05	$52.39	$26.20	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$14.30	$7.15	$61.92	$30.96	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$17.60	$8.80	$76.21	$38.10	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$19.80	$9.90	$85.73	$42.87	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$23.10	$11.55	$100.02	$50.01	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$27.50	$13.75	$119.08	$59.54	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$30.80	$15.40	$133.36	$66.68	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$33.00	$16.50	$142.89	$71.45	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment**		Percent of State 1989	Family Size and Annual Income					
First Child	Second Child***	First Child	Second Child***	Median Family Income	7	8	9	10	11	12
$0	$0	$0	$0	0%	0	0	0	0	0	0
$0.00	$0.00	$0.00	$0.00	1% - 5%	1 - 3,510	1 - 3,588	1 - 3,666	1 - 3,744	1 - 3,822	1 - 3,900
$2.20	$1.10	$9.53	$4.76	6% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$3.30	$1.65	$14.29	$7.14	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$4.40	$2.20	$19.05	$9.53	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$5.50	$2.75	$23.82	$11.91	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$7.70	$3.85	$33.34	$16.67	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$9.90	$4.95	$42.87	$21.43	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$12.10	$6.05	$52.39	$26.20	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$14.30	$7.15	$61.92	$30.96	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$17.60	$8.80	$76.21	$38.10	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$19.80	$9.90	$85.73	$42.87	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$23.10	$11.55	$100.02	$50.01	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$27.50	$13.75	$119.08	$59.54	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$30.80	$15.40	$133.36	$66.68	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$33.00	$16.50	$142.89	$71.45	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

*Part-time care is defined as less than six (6) hours of care per day.

**The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

***The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

(e)-(h) (No change.)

10:82-5.3 Payment for child care through Title IV-A funds

(a)-(f) (No change.)

(g) Statewide maximum child care payment rates are based upon either the age or special needs status of the child and on the number of hours of care provided in the various types of child care arrangements. Included in the types of arrangements are registered homes, approved homes, in-home care, child care centers and day camps, and the hours of care provided (that is, full and part-time day care and care before and after school and during school recesses).

1.-4. (No change.)

5. The maximum authorized rates for child care are set forth in Tables I, II and III below, as determined by the type of child care arrangements, and based upon either the age or special needs status of the child and the hours of care provided.

[IV-A CHILD CARE MAXIMUM RATES

Table I

These rates shall be utilized for:

LICENSED CHILD CARE CENTERS, SCHOOL-AGE PROGRAMS, SUMMER DAY CAMPS

HOURS OF CARE PROVIDED

Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time† 4 or 5 hrs. per day	One-Half Time† 2 or 3 hrs. per day	One-Quarter Time† 1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$116.20	$87.15	$58.10	$29.05
Daily	$ 23.24	$17.43	$11.62	$ 5.81
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$116.20	$87.15	$58.10	$29.05
Daily	$ 23.24	$17.43	$11.62	$ 5.81
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$ 95.80	$71.85	$47.90	$23.95
Daily	$ 19.16	$14.37	$ 9.58	$ 4.79
Kindergartners & School-Agers (5-13 yrs.)				
Weekly	$ 95.80	$71.85	$47.90	$23.95
Daily	$ 19.16	$14.37	$ 9.58	$ 4.79
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$116.20	$87.15	$58.10	$29.05
Daily	$ 23.24	$17.43	$11.62	$ 5.81
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$116.20	$87.15	$58.10	$29.05
Daily	$ 23.24	$17.43	$11.62	$ 5.81
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$ 95.80	$71.85	$47.90	$23.95
Daily	$ 19.16	$14.37	$ 9.58	$ 4.79

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and fifteen minutes is rounded to two hours.]

[IV-A CHILD CARE MAXIMUM RATES

Table II

These rates shall be utilized for:

REGISTERED FAMILY DAY CARE HOMES

HOURS OF CARE PROVIDED

Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time† 4 or 5 hrs. per day	One-Half Time† 2 or 3 hrs. per day	One-Quarter Time† 1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$ 91.80	$68.85	$45.90	$22.95
Daily	$ 18.36	$13.77	$ 9.18	$ 4.59
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$ 91.80	$68.85	$45.90	$22.95
Daily	$ 18.36	$13.77	$ 9.18	$ 4.59
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$ 71.40	$53.55	$35.70	$17.85
Daily	$ 14.28	$10.71	$ 7.14	$ 3.57
Kindergartners & School-Agers (5-13 yrs.)				
Weekly	$ 71.40	$53.55	$35.70	$17.85
Daily	$ 14.28	$10.71	$ 7.14	$ 3.57
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$112.20	$84.15	$56.10	$28.05
Daily	$ 22.44	$16.83	$11.22	$ 5.61
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$112.20	$84.15	$56.10	$28.05
Daily	$ 22.44	$16.83	$11.22	$ 5.61
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$ 91.80	$68.85	$45.90	$22.95
Daily	$ 18.36	$13.77	$ 9.18	$ 4.59

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and fifteen minutes is rounded to two hours.]

[IV-A CHILD CARE MAXIMUM RATES

Table III

These rates shall be utilized for:

APPROVED HOME DAY CARE

Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time† 4 or 5 hrs. per day	One-Half Time† 2 or 3 hrs. per day	One-Quarter Time† 1 hr. per day
		HOURS OF CARE PROVIDED		
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$55.10	$41.30	$27.55	$13.75
Daily	$11.02	$ 8.26	$ 5.51	$ 2.75
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$55.10	$41.30	$27.55	$13.75
Daily	$11.02	$ 8.26	$ 5.51	$ 2.75
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$42.80	$32.10	$21.40	$10.70
Daily	$ 8.56	$ 6.42	$ 4.28	$ 2.14
Kindergartners & School-Agers (5-13 yrs.)				
Weekly	$42.80	$32.10	$21.40	$10.70
Daily	$ 8.56	$ 6.42	$ 4.28	$ 2.14
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$67.30	$50.50	$33.65	$16.80
Daily	$13.46	$10.10	$ 6.73	$ 3.36
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$67.30	$50.50	$33.65	$16.80
Daily	$13.46	$10.10	$ 6.73	$ 3.36
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$55.10	$41.30	$27.55	$13.75
Daily	$11.02	$ 8.26	$ 5.51	$ 2.75

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and fifteen minutes is rounded to two hours.]

IV-A CHILD CARE MAXIMUM RATES

Table I

These rates shall be utilized for:

LICENSED CHILD CARE CENTERS, SCHOOL-AGE PROGRAMS, SUMMER DAY CAMPS

	HOURS OF CARE PROVIDED			
	Full-Time	Three-Quarter Time*	One-Half Time*	One-Quarter Time*
Child's Service Category:	6 hrs. or more per day	4 or 5 hrs. per day	2 or 3 hrs. per day	1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$118.50	$88.90	$59.25	$29.65
Daily	$ 23.70	$17.78	$11.85	$ 5.93
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$118.50	$88.90	$59.25	$29.65
Daily	$ 23.70	$17.78	$11.85	$ 5.93
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$ 97.70	$73.30	$48.85	$24.45
Daily	$ 19.54	$14.66	$ 9.77	$ 4.89
Kindergarteners & School-Agers (5-13 yrs.)				
Weekly	$ 97.70	$73.30	$48.85	$24.45
Daily	$ 19.54	$14.66	$ 9.77	$ 4.89
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$118.50	$88.90	$59.25	$29.65
Daily	$ 23.70	$17.78	$11.85	$ 5.93
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$118.50	$88.90	$59.25	$29.65
Daily	$ 23.70	$17.78	$11.85	$ 5.93
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$ 97.70	$73.30	$48.95	$24.45
Daily	$ 19.54	$14.66	$ 9.77	$ 4.89

*Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and fifteen minutes is rounded to two hours.

IV-A CHILD CARE MAXIMUM RATES

Table II

These rates shall be utilized for:

REGISTERED FAMILY DAY CARE HOMES

	HOURS OF CARE PROVIDED			
Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time* 4 or 5 hrs. per day	One-Half Time* 2 or 3 hrs. per day	One-Quarter Time* 1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$ 93.60	$70.20	$46.80	$23.40
Daily	$ 18.72	$14.04	$ 9.36	$ 4.68
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$ 93.60	$70.20	$46.80	$23.40
Daily	$ 18.72	$14.04	$ 9.36	$ 4.68
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$ 73.30	$54.95	$36.65	$18.30
Daily	$ 14.66	$10.99	$ 7.33	$ 3.66
Kindergartners & School-Agers (5-13 yrs.)				
Weekly	$ 73.30	$54.95	$36.65	$18.30
Daily	$ 14.66	$10.99	$ 7.33	$ 3.66
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$114.00	$85.50	$57.00	$28.50
Daily	$ 22.80	$17.10	$11.40	$ 5.70
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$114.00	$85.50	$57.00	$28.50
Daily	$ 22.80	$17.10	$11.40	$ 5.70
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$ 93.60	$70.20	$46.80	$23.40
Daily	$ 18.72	$14.04	$ 9.36	$ 4.68

*Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and fifteen minutes is rounded to two hours.

IV-A CHILD CARE MAXIMUM RATES

Table III

These rates shall be utilized for:

APPROVED HOME DAY CARE

	HOURS OF CARE PROVIDED			
Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time* 4 or 5 hrs. per day	One-Half Time* 2 or 3 hrs. per day	One-Quarter Time* 1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$56.20	$42.15	$28.10	$14.05
Daily	$11.24	$ 8.43	$ 5.62	$ 2.81
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$56.20	$42.15	$28.10	$14.05
Daily	$11.24	$ 8.43	$ 5.62	$ 2.81
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$44.00	$33.00	$22.00	$11.00
Daily	$ 8.80	$ 6.60	$ 4.40	$ 2.20
Kindergarteners & School-Agers (5-13 yrs.)				
Weekly	$44.00	$33.00	$22.00	$11.00
Daily	$ 8.80	$ 6.60	$ 4.40	$ 2.20
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$68.40	$51.30	$34.20	$17.10
Daily	$13.68	$10.26	$ 6.84	$ 3.42
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$68.40	$51.30	$34.20	$17.10
Daily	$13.68	$10.26	$ 6.84	$ 3.42
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$56.20	$42.15	$28.10	$14.05
Daily	$11.24	$ 8.43	$ 5.62	$ 2.81

*Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and fifteen minutes is rounded to two hours.

(h) (No change.)

10:86-10.2 Types of care and duration of child care payments

(a)-(c) (No change.)

(d) The maximum child care payment rates, set forth in Tables I, II and III below, specify weekly and daily rates for the various age categories of children based on the hours of care provided.

1.-3. (No change.)

[FDP CHILD CARE MAXIMUM RATES

Table I

These rates shall be utilized for:

LICENSED CHILD CARE CENTERS, SCHOOL-AGE PROGRAMS, SUMMER DAY CAMPS

	HOURS OF CARE PROVIDED			
Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time† 4 or 5 hrs. per day	One-Half Time† 2 or 3 hrs. per day	One-Quarter Time† 1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$116.20	$87.15	$58.10	$29.05
Daily	$ 23.24	$17.43	$11.62	$ 5.81
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$116.20	$87.15	$58.10	$29.05
Daily	$ 23.24	$17.43	$11.62	$ 5.81
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$ 95.80	$71.85	$47.90	$23.95
Daily	$ 19.16	$14.37	$ 9.58	$ 4.79
Kindergartners & School-Agers (5-13 yrs.)				
Weekly	$ 95.80	$71.85	$47.90	$23.95
Daily	$ 19.16	$14.37	$ 9.58	$ 4.79
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$116.20	$87.15	$58.10	$29.05
Daily	$ 23.24	$17.43	$11.62	$ 5.81
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$116.20	$87.15	$58.10	$29.05
Daily	$ 23.24	$17.43	$11.62	$ 5.81
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$ 95.80	$71.85	$47.90	$23.95
Daily	$ 19.16	$14.37	$ 9.58	$ 4.79

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and 15 minutes is rounded to two hours.]

[FDP CHILD CARE MAXIMUM RATES

Table II

These rates shall be utilized for:

REGISTERED FAMILY DAY CARE HOMES

	HOURS OF CARE PROVIDED			
Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time† 4 or 5 hrs. per day	One-Half Time† 2 or 3 hrs. per day	One-Quarter Time† 1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$ 91.80	$68.85	$45.90	$22.95
Daily	$ 18.36	$13.77	$ 9.18	$ 4.59
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$ 91.80	$68.85	$45.90	$22.95
Daily	$ 18.36	$13.77	$ 9.18	$ 4.59
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$ 71.40	$53.55	$35.70	$17.85
Daily	$ 14.28	$10.71	$ 7.14	$ 3.57
Kindergartners & School-Agers (5 up to 13 yrs.)				
Weekly	$ 71.40	$53.55	$35.70	$17.85
Daily	$ 14.28	$10.71	$ 7.14	$ 3.57
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$112.20	$84.15	$56.10	$28.05
Daily	$ 22.44	$16.83	$11.22	$ 5.61
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$112.20	$84.15	$56.10	$28.05
Daily	$ 22.44	$16.83	$11.22	$ 5.61
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$ 91.80	$68.85	$45.90	$22.95
Daily	$ 18.36	$13.77	$ 9.18	$ 4.59

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and 15 minutes is rounded to two hours.]

[FDP CHILD CARE MAXIMUM RATES

Table III

These rates shall be utilized for:

APPROVED HOME DAY CARE

	HOURS OF CARE PROVIDED			
Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time† 4 or 5 hrs. per day	One-Half Time† 2 or 3 hrs. per day	One-Quarter Time† 1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$55.10	$41.30	$27.55	$13.75
Daily	$11.02	$ 8.26	$ 5.51	$ 2.75
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$55.10	$41.30	$27.55	$13.75
Daily	$11.02	$ 8.26	$ 5.51	$ 2.75
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$42.80	$32.10	$21.40	$10.70
Daily	$ 8.56	$ 6.42	$ 4.28	$ 2.14
Kindergartners & School-Agers (5 up to 13 yrs.)				
Weekly	$42.80	$32.10	$21.40	$10.70
Daily	$ 8.56	$ 6.42	$ 4.28	$ 2.14
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$67.30	$50.50	$33.65	$16.80
Daily	$13.46	$10.10	$ 6.73	$ 3.36
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$67.30	$50.50	$33.65	$16.80
Daily	$13.46	$10.10	$ 6.73	$ 3.36
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$55.10	$41.30	$27.55	$13.75
Daily	$11.02	$ 8.26	$ 5.51	$ 2.75

†Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and 15 minutes is rounded to two hours.]

IV-A CHILD CARE MAXIMUM RATES

Table I

These rates shall be utilized for:

LICENSED CHILD CARE CENTERS, SCHOOL-AGE PROGRAMS, SUMMER DAY CAMPS

	HOURS OF CARE PROVIDED			
Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time* 4 or 5 hrs. per day	One-Half Time* 2 or 3 hrs. per day	One-Quarter Time* 1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$118.50	$88.90	$59.25	$29.65
Daily	$ 23.70	$17.78	$11.85	$ 5.93
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$118.50	$88.90	$59.20	$29.65
Daily	$ 23.70	$17.78	$11.85	$ 5.93
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$ 97.70	$73.30	$48.85	$24.45
Daily	$ 19.54	$14.66	$ 9.77	$ 4.89
Kindergarteners & School-Agers (5-13 yrs.)				
Weekly	$ 97.70	$73.30	$48.85	$24.45
Daily	$ 19.54	$14.66	$ 9.77	$ 4.89
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$118.50	$88.90	$59.25	$29.65
Daily	$ 23.70	$17.78	$11.85	$ 5.93
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$118.50	$88.90	$59.25	$29.65
Daily	$ 23.70	$17.78	$11.85	$ 5.93
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$ 97.70	$73.30	$48.85	$24.45
Daily	$ 19.54	$14.66	$ 9.77	$ 4.89

*Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and 15 minutes is rounded to two hours.

IV-A CHILD CARE MAXIMUM RATES

Table II

These rates shall be utilized for:

REGISTERED FAMILY DAY CARE HOMES

	HOURS OF CARE PROVIDED			
Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time* 4 or 5 hrs. per day	One-Half Time* 2 or 3 hrs. per day	One-Quarter Time* 1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$ 93.60	$70.20	$46.80	$23.40
Daily	$ 18.72	$14.04	$ 9.36	$ 4.68
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$ 93.60	$70.20	$46.80	$23.40
Daily	$ 18.72	$14.04	$ 9.36	$ 4.68
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$ 73.30	$54.95	$36.65	$18.30
Daily	$ 14.66	$10.99	$ 7.33	$ 3.66
Kindergarteners & School-Agers (5 up to 13 yrs.)				
Weekly	$ 73.30	$54.95	$36.65	$18.30
Daily	$ 14.66	$10.99	$ 7.33	$ 3.66
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$114.00	$85.50	$57.00	$28.50
Daily	$ 22.80	$17.10	$11.40	$ 5.70
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$114.00	$85.50	$57.00	$28.50
Daily	$ 22.80	$17.10	$11.40	$ 5.70
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$ 93.60	$70.20	$46.80	$23.40
Daily	$ 18.72	$14.04	$ 9.36	$ 4.68

*Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and 15 minutes is rounded to two hours.

IV-A CHILD CARE MAXIMUM RATES

Table III

These rates shall be utilized for:

APPROVED HOME DAY CARE

	HOURS OF CARE PROVIDED			
Child's Service Category:	Full-Time 6 hrs. or more per day	Three-Quarter Time* 4 or 5 hrs. per day	One-Half Time* 2 or 3 hrs. per day	One-Quarter Time* 1 hr. per day
Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$56.20	$42.15	$28.10	$14.05
Daily	$11.24	$ 8.43	$ 5.62	$ 2.81
Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$56.20	$42.15	$28.10	$14.05
Daily	$11.24	$ 8.43	$ 5.62	$ 2.81
Pre-Schoolers (2.5 up to 5 yrs.)				
Weekly	$44.00	$33.00	$22.00	$11.00
Daily	$ 8.80	$ 6.60	$ 4.40	$ 2.20
Kindergarteners & School-Agers (5 up to 13 yrs.)				
Weekly	$44.00	$33.00	$22.00	$11.00
Daily	$ 8.80	$ 6.60	$ 4.40	$ 2.20
Special Needs Infants/Toddlers (0 up to 2 yrs.)				
Weekly	$68.40	$51.30	$34.20	$17.10
Daily	$13.68	$10.26	$ 6.84	$ 3.42
Special Needs Early Pre-Schoolers (2 up to 2.5 yrs.)				
Weekly	$68.40	$51.30	$34.20	$17.10
Daily	$13.68	$10.26	$ 6.84	$ 3.42
Special Needs Child(ren) (2.5 up to 19 yrs.)				
Weekly	$56.20	$42.15	$28.10	$14.05
Daily	$11.24	$ 8.43	$ 5.62	$ 2.81

*Care given for any portion of an hour shall be rounded to the next full hour. For example, one hour and 15 minutes is rounded to two hours.

10:86-10.6 Co-payment scales

(a) (No change.)

(b) The co-payment scales are as follows:

1.-2. (No change.)

[Table I

CHILD CARE CO-PAYMENT SCALE

FULL TIME CARE†

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment††		Percent of State 1989	Family Size and Annual Income††††				
First Child	Second Child†††	First Child	Second Child†††	Median Family Income	2	3	4	5	6
$1.10	$0.55	$4.76	$2.38	0% - 5%	0 - 1,768	0 - 2,184	0 - 2,600	0 - 3,016	0 - 3,432
$4.40	$2.20	$19.05	$9.53	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$6.60	$3.30	$28.58	$14.29	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$9.90	$4.95	$42.87	$21.43	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$12.10	$6.05	$52.39	$26.20	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$15.40	$7.70	$66.68	$33.34	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$19.80	$9.90	$85.73	$42.87	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$24.20	$12.10	$104.79	$52.39	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$29.70	$14.85	$128.60	$64.30	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$35.20	$17.60	$152.42	$76.21	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$40.70	$20.35	$176.23	$88.12	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$47.30	$23.65	$204.81	$102.40	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$55.00	$27.50	$238.15	$119.08	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$62.70	$31.35	$271.49	$135.75	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$67.10	$33.55	$290.54	$145.27	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment††		Percent of State 1989	Family Size and Annual Income					
First Child	Second Child†††	First Child	Second Child†††	Median Family Income	7	8	9	10	11	12
$1.10	$0.55	$4.76	$2.38	0% - 5%	0 - 3,510	0 - 3,588	0 - 3,666	0 - 3,744	0 - 3,822	0 - 3,900
$4.40	$2.20	$19.05	$9.53	5% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$6.60	$3.30	$28.58	$14.29	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$9.90	$4.95	$42.87	$21.43	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$12.10	$6.05	$52.39	$26.20	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$15.40	$7.70	$66.68	$33.34	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$19.80	$9.90	$85.73	$42.87	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$24.20	$12.10	$104.79	$52.39	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$29.70	$14.85	$128.60	$64.30	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$35.20	$17.60	$152.42	$76.21	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$40.70	$20.35	$176.23	$88.12	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$47.30	$23.65	$204.81	$102.40	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$55.00	$27.50	$238.15	$119.08	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$62.70	$31.35	$271.49	$135.75	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$67.10	$33.55	$290.54	$145.27	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

†Full time care is defined as six (6) or more hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $1.00 ($2.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.]

[Table II
CHILD CARE CO-PAYMENT SCALE
PART-TIME CARE†

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment††		Percent of State 1989	Family Size and Annual Income††††				
First Child	Second Child†††	First Child	Second Child†††	Median Family Income	2	3	4	5	6
$0.00	$0.00	$0.00	$0.00	0% - 5%	0 - 1,768	0 - 2,184	0 - 2,600	0 - 3,016	0 - 3,432
$2.20	$1.10	$9.53	$4.76	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$3.30	$1.65	$14.29	$7.14	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$4.40	$2.20	$19.05	$9.53	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$5.50	$2.75	$23.82	$11.91	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$7.70	$3.85	$33.34	$16.67	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$9.90	$4.95	$42.87	$21.43	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$12.10	$6.05	$52.39	$26.20	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$14.30	$7.15	$61.92	$30.96	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$17.60	$8.80	$76.21	$38.10	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$19.80	$9.90	$85.73	$42.87	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$23.10	$11.55	$100.02	$50.01	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 E 31,197	33,174 - 36,188	37,750 - 41,180
$27.50	$13.75	$119.08	$59.54	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$30.80	$15.40	$133.36	$66.68	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$33.00	$16.50	$142.89	$71.45	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment††		Percent of State 1989	Family Size and Annual Income					
First Child	Second Child†††	First Child	Second Child†††	Median Family Income	7	8	9	10	11	12
$0.00	$0.00	$0.00	$0.00	0% - 5%	0 - 3,510	0 - 3,588	0 - 3,666	0 - 3,744	0 - 3,822	0 - 3,900
$2.20	$1.10	$9.53	$4.76	5% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$3.30	$1.65	$14.29	$7.14	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$4.40	$2.20	$19.05	$9.53	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$5.50	$2.75	$23.82	$11.91	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$7.70	$3.85	$33.34	$16.67	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$9.90	$4.95	$42.87	$21.43	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$12.10	$6.05	$52.39	$26.20	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$14.30	$7.15	$61.92	$30.96	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$17.60	$8.80	$76.21	$38.10	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$19.80	$9.90	$85.73	$42.87	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$23.10	$11.55	$100.02	$50.01	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$27.50	$13.75	$119.08	$59.54	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$30.80	$15.40	$133.36	$66.68	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$33.00	$16.50	$142.89	$71.45	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

†Part-time care is defined as less than six (6) hours of care per day.

††The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

†††The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

††††Families with a maximum gross income for their family size in excess of their scale will be assessed an additional weekly fee of $.50 ($1.00 for a Bi-weekly fee) for each $1,000 of gross income above their scale.]

Table I
CHILD CARE CO-PAYMENT SCHEDULE
FULL TIME CARE*

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment**		Percent of State 1989	Family Size and Annual Income				
First Child	Second Child***	First Child	Second Child***	Median Family Income	1 or 2	3	4	5	6
$0	$0	$0	$0	0%	0	0	0	0	0
$1.10	$0.55	$4.76	$2.38	1% - 5%	1 - 1,768	1 - 2,184	1 - 2,600	1 - 3,016	1 - 3,432
$4.40	$2.20	$19.05	$9.53	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$6.60	$3.30	$28.58	$14.29	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$9.90	$4.95	$42.87	$21.43	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$12.10	$6.05	$52.39	$26.20	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$15.40	$7.70	$66.68	$33.34	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$19.80	$9.90	$85.73	$42.87	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$24.20	$12.10	$104.79	$52.39	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$29.70	$14.85	$128.60	$64.30	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$35.20	$17.60	$152.42	$76.21	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$40.70	$20.35	$176.23	$88.12	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$47.30	$23.65	$204.81	$102.40	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$55.00	$27.50	$238.15	$119.08	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$62.70	$31.35	$271.49	$135.75	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$67.10	$33.55	$290.54	$145.27	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Full Time Co-Payment		Monthly Full Time Co-Payment**		Percent of State 1989	Family Size and Annual Income					
First Child	Second Child***	First Child	Second Child***	Median Family Income	7	8	9	10	11	12
$0	$0	$0	$0	0%	0	0	0	0	0	0
$1.10	$0.55	$4.76	$2.38	1% - 5%	1 - 3,510	1 - 3,588	1 - 3,666	1 - 3,744	1 - 3,822	1 - 3,900
$4.40	$2.20	$19.05	$9.53	5% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$6.60	$3.30	$28.58	$14.29	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$9.90	$4.95	$42.87	$21.43	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$12.10	$6.05	$52.39	$26.20	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$15.40	$7.70	$66.68	$33.34	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$19.80	$9.90	$85.73	$42.87	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$24.20	$12.10	$104.79	$52.39	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$29.70	$14.85	$128.60	$64.30	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$35.20	$17.60	$152.42	$76.21	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$40.70	$20.35	$176.23	$88.12	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$47.30	$23.65	$204.81	$102.40	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$55.00	$27.50	$238.15	$119.08	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$62.70	$31.35	$271.49	$135.75	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$67.10	$33.55	$290.54	$145.27	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

*Full time care is defined as six (6) or more hours of care per day.

**The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

***The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

Table II
CHILD CARE CO-PAYMENT SCHEDULE
PART-TIME CARE*

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment**		Percent of State 1989 Median Family Income	Family Size and Annual Income				
First Child	Second Child***	First Child	Second Child***		1 or 2	3	4	5	6
$0	$0	$0	$0	0%	0	0	0	0	0
$0.00	$0.00	$0.00	$0.00	1% - 5%	1 - 1,768	1 - 2,184	1 - 2,600	1 - 3,016	1 - 3,432
$2.20	$1.10	$9.53	$4.76	6% - 10%	1,769 - 3,536	2,185 - 4,368	2,601 - 5,200	3,017 - 6,031	3,433 - 6,863
$3.30	$1.65	$14.29	$7.14	11% - 15%	3,537 - 5,304	4,369 - 6,552	5,201 - 7,799	6,032 - 9,047	6,864 - 10,295
$4.40	$2.20	$19.05	$9.53	16% - 20%	5,305 - 7,071	6,553 - 8,735	7,800 - 10,399	9,048 - 12,063	10,296 - 13,727
$5.50	$2.75	$23.82	$11.91	21% - 25%	7,072 - 8,839	8,736 - 10,919	10,400 - 12,999	12,064 - 15,079	13,728 - 17,159
$7.70	$3.85	$33.34	$16.67	26% - 30%	8,840 - 10,607	10,920 - 13,103	13,000 - 15,599	15,080 - 18,094	17,160 - 20,590
$9.90	$4.95	$42.87	$21.43	31% - 35%	10,608 - 12,375	13,104 - 15,287	15,600 - 18,198	18,095 - 21,110	20,591 - 24,022
$12.10	$6.05	$52.39	$26.20	36% - 40%	12,376 - 14,143	15,288 - 17,471	18,199 - 20,798	21,111 - 24,126	24,023 - 27,454
$14.30	$7.15	$61.92	$30.96	41% - 45%	14,144 - 15,911	17,472 - 19,655	20,799 - 23,398	24,127 - 27,141	27,455 - 30,885
$17.60	$8.80	$76.21	$38.10	46% - 50%	15,912 - 17,679	19,656 - 21,839	23,399 - 25,998	27,142 - 30,157	30,886 - 34,317
$19.80	$9.90	$85.73	$42.87	51% - 55%	17,680 - 19,446	21,840 - 24,022	25,999 - 28,597	30,158 - 33,173	34,318 - 37,749
$23.10	$11.55	$100.02	$50.01	56% - 60%	19,447 - 21,214	24,023 - 26,206	28,598 - 31,197	33,174 - 36,188	37,750 - 41,180
$27.50	$13.75	$119.08	$59.54	61% - 65%	21,215 - 22,982	26,207 - 28,390	31,198 - 33,797	36,189 - 39,204	41,181 - 44,612
$30.80	$15.40	$133.36	$66.68	66% - 70%	22,983 - 24,750	28,391 - 30,574	33,798 - 36,397	39,205 - 42,220	44,613 - 48,044
$33.00	$16.50	$142.89	$71.45	71% - 75%	24,751 - 26,518	30,575 - 32,758	36,398 - 38,996	42,221 - 45,236	48,045 - 51,476

Weekly Part-Time Co-Payment		Monthly Part-Time Co-Payment**		Percent of State 1989 Median Family Income	Family Size and Annual Income					
First Child	Second Child***	First Child	Second Child***		7	8	9	10	11	12
$0	$0	$0	$0	0%	0	0	0	0	0	0
$0.00	$0.00	$0.00	$0.00	1% - 5%	1 - 3,510	1 - 3,588	1 - 3,666	1 - 3,744	1 - 3,822	1 - 3,900
$2.20	$1.10	$9.53	$4.76	6% - 10%	3,511 - 7,019	3,589 - 7,176	3,667 - 7,332	3,745 - 7,488	3,823 - 7,644	3,901 - 7,800
$3.30	$1.65	$14.29	$7.14	11% - 15%	7,020 - 10,529	7,177 - 10,763	7,333 - 10,997	7,489 - 11,231	7,645 - 11,465	7,801 - 11,699
$4.40	$2.20	$19.05	$9.53	16% - 20%	10,530 - 14,039	10,764 - 14,351	10,998 - 14,663	11,232 - 14,975	11,466 - 15,287	11,700 - 15,599
$5.50	$2.75	$23.82	$11.91	21% - 25%	14,040 - 17,548	14,352 - 17,939	14,664 - 18,329	14,976 - 18,719	15,288 - 19,109	15,600 - 19,499
$7.70	$3.85	$33.34	$16.67	26% - 30%	17,549 - 21,058	17,940 - 21,527	18,330 - 21,995	18,720 - 22,463	19,110 - 22,931	19,500 - 23,399
$9.90	$4.95	$42.87	$21.43	31% - 35%	21,059 - 24,568	21,528 - 25,114	21,996 - 25,660	22,464 - 26,206	22,932 - 26,752	23,400 - 27,298
$12.10	$6.05	$52.39	$26.20	36% - 40%	24,569 - 28,077	25,115 - 28,702	25,661 - 29,326	26,207 - 29,950	26,753 - 30,574	27,299 - 31,198
$14.30	$7.15	$61.92	$30.96	41% - 45%	28,078 - 31,587	28,703 - 32,290	29,327 - 32,992	29,951 - 33,694	30,575 - 34,396	31,199 - 35,098
$17.60	$8.80	$76.21	$38.10	46% - 50%	31,588 - 35,097	32,291 - 35,878	32,993 - 36,658	33,695 - 37,438	34,397 - 38,218	35,099 - 38,998
$19.80	$9.90	$85.73	$42.87	51% - 55%	35,098 - 38,606	35,879 - 39,465	36,659 - 40,323	37,439 - 41,181	38,219 - 42,039	38,999 - 42,897
$23.10	$11.55	$100.02	$50.01	56% - 60%	38,607 - 42,116	39,466 - 43,053	40,324 - 43,989	41,182 - 44,925	42,040 - 45,861	42,898 - 46,797
$27.50	$13.75	$119.08	$59.54	61% - 65%	42,117 - 45,625	43,054 - 46,641	43,990 - 47,655	44,926 - 48,669	45,862 - 49,683	46,798 - 50,697
$30.80	$15.40	$133.36	$66.68	66% - 70%	45,626 - 49,135	46,642 - 50,229	47,656 - 51,321	48,670 - 52,413	49,684 - 53,505	50,698 - 54,597
$33.00	$16.50	$142.89	$71.45	71% - 75%	49,136 - 52,645	50,230 - 53,816	51,322 - 54,986	52,414 - 56,156	53,506 - 57,326	54,598 - 58,496

*Part-time care is defined as less than six (6) hours of care per day.

**The monthly co-payment is calculated by multiplying the weekly co-payment by 4.33.

***The co-payments listed are for the first and second child of the family receiving care. The co-payment for the second child receiving care is calculated at one-half of the full co-payment for that child. No additional co-payment is charged for the third or subsequent child(ren) in the family receiving care.

(c)-(f) (No change.)

(a)

DIVISION OF FAMILY DEVELOPMENT

Public Assistance Manual
Social Security Numbers
Proposed Recodification with Amendment: N.J.A.C. 10:81-11.3 to 10:81-2.6(d)
Proposed Amendments: N.J.A.C. 10:81-2.6, 3.4 and 11.2

Authorized By: William Waldman, Commissioner, Department of Human Services.
Authority: N.J.S.A. 44:10-3.
Proposal Number: PRN 1994-51.

Submit comments by February 17, 1994 to:
Marion E. Reitz, Director
Division of Family Development
CN 716
Trenton, New Jersey 08625

The agency proposal follows:

Summary

N.J.A.C. 10:81-11.2(a)1 and 11.3 are being deleted and recodified as N.J.A.C. 10:81-2.6(d), with some modifications. N.J.A.C. 10:81-11 deals specifically with child support and paternity rules. The current text at N.J.A.C. 10:81-11.2(a)1 and 11.3 deal with eligibility requirements (other than need) for the Aid to Families with Dependent Children (AFDC) program and, therefore, do not belong under rules concerning child support and paternity determinations.

Inasmuch as N.J.A.C. 10:81-2.6 deals with eligibility factors other than need, this is the appropriate section to place the current rules from N.J.A.C. 10:81-11.2(a)1 and 11.3. The rules at N.J.A.C. 10:81-11.2(a)1 and 11.3 are in accordance with Federal regulations at 45 C.F.R. 205.52 which state that, as a condition of eligibility, each applicant for, or recipient of, assistance is required to furnish a Social Security Number (SSN). If such cannot be provided (either because such has not been issued or is not known), the applicant or recipient has to apply for such number with the Social Security Administration (SSA).

As stated above, text from N.J.A.C. 10:81-11.3 is now recodified as N.J.A.C. 10:81-2.6(d) with some revisions. Those revisions are found at N.J.A.C. 10:81-2.6(d)3iii and 3iv. N.J.A.C. 10:81-2.6(d)3iii and 3iii(2) provide that public assistance applicants who are legal residents but not United States citizens are to be enumerated through completion of Form PA-55 as opposed to Form SS-5. The use of Form PA-55 for this purpose is not a new procedure. This procedure is currently found at N.J.A.C. 10:81-11.3(c)3i but it was not clearly set forth at N.J.A.C. 10:81-11.3(c)3. N.J.A.C. 10:81-2.6(d)3iii(l) clarifies that for enumeration purposes, not all U.S. born individuals are U.S. citizens and provides an example of some of those situations when this could occur. N.J.A.C. 10:81-2.6(d)3iv clarifies that since applicants for AFDC-N need not be citizens or lawfully admitted aliens (as stated at N.J.A.C. 10:81-3.10), illegal aliens do not have to meet the enumeration requirements.

Text at N.J.A.C. 10:81-2.6(e) deals with the "Hospital Enumeration at Birth Project" which was implemented by the SSA a few years ago. The program enables a parent of a newborn to apply for a SSN for the newborn in the hospital as part of the State's birth registration process. Participating hospitals provide this service in conjunction with the New Jersey Department of Health, Bureau of Vital Statistics (BVS). The BVS electronically transmits SSN application information received from the hospitals to the SSA in Baltimore, Maryland for enumeration of the child. The assigned SSN card is then sent to the child at the parent's home address.

If this service is available at the hospital and the parent elects to apply, the parent is given Form SSA-2853/OP4, "Message From Social Security," that bears the name of the newborn for whom SSN application has been made and the dated signature of an authorized hospital official. If that form contains the foregoing identifying information, it serves as satisfactory verification that the family/household has applied for a SSN on behalf of the newborn for AFDC and food stamp purposes provided that other documentation is available to connect the child to the parent in AFDC or to a member of the food stamp household.

In instances of "enumeration at birth," the CWA worker will not need to complete Form SS-5," "Application for a Social Security Number Card," for the newborn. The CWA shall, however, request proof of receipt of the SSN after six months from the child's birth have lapsed or at time of the recipient's next redetermination/recertification, whichever occurs first. If a SSN has not been assigned to the newborn at that time, then the CWA shall complete the Form SS-5 for such newborn.

If the family is unable to provide Form SSA 2853/OP4, then the child shall be enumerated by the CWA through completion of a Form SS-5 following current application procedures. CWAs shall not contact hospitals to verify that a child was enumerated through those facilities.

Text at N.J.A.C. 10:81-3.4(e) provides that the CWA shall request proof of receipt of the SSN after six months from the child's birth have lapsed or at time of the recipient's next redetermination, whichever occur first. Form SS-5 will need to be completed for the newborn if a SSN has not yet been assigned.

Social Impact

The recodification itself from N.J.A.C. 10:81-11.2(a)1 and 11.3 to 10:81-2.6(d) will not have an impact, inasmuch as current text is simply being moved from one section to another for clarification purposes. The text added at N.J.A.C. 10:81-2.6(d)3iii and 3(l), for clarification purposes, provides that not all U.S. born individuals are U.S. citizens and such individuals should be referred to the SSA office for enumeration through use of Form PA-55. This clarification will ensure that such individuals are properly referred to the SSA office via Form PA-55 instead of Form SS-5. Text at N.J.A.C. 10:81-2.6(d)3iv will not have an impact, inasmuch as this is current rule, as found at N.J.A.C. 10:81-3.10, but placed here for clarification purposes. Text at N.J.A.C. 10:81-2.6(e) will not have any additional social impact, inasmuch as this is a program that was implemented by the Federal Social Security Administration a few years ago. The program itself is optional for the hospital and the client. The only impact that it could have is that clients who opt to have the child enumerated at the hospital may be able to obtain the SSN for the child faster than if they waited till they left the hospital to do so. Text at N.J.A.C. 10:81-3.4(e) does not have any additional impact, since this reflects text added at N.J.A.C. 10:81-2.6(e)5 and is placed here also to clarify that at redeterminations CWAs must ensure that if a SSN has not been assigned to the newborn, then the CWA shall complete the Form SS-5 for such newborn.

Economic Impact

Since the main purpose and effect of the proposed recodification with amendments is to merely clarify existing rules, and provide information on an existing program implemented by the SSA, the economic impact would be small. The recodification itself from N.J.A.C. 10:81-11.3 to 2.6(d) will not have an impact, inasmuch as current text is simply being moved from one section to another. The text at N.J.A.C. 10:81-2.6(d)3iii clarifies which individuals are to be referred to the SSA office for enumeration through use of Form PA-55 instead of Form SS-5. This may result in some small savings only in those situations where a CWA worker may have been improperly using the wrong form for the referral. N.J.A.C. 10:81-2.6(e) will not have a monetary impact on our clients, agencies, or the Department since the "Hospital Enumeration at Birth Project" is a program implemented by the SSA which is optional to the hospital and welfare clients. Clients who opt to use the program are not getting any additional benefits. N.J.A.C. 10:81-3.4(e) has no additional impact since this text is the same text found at N.J.A.C. 10:81-2.6(e) and it is being placed here to further clarify CWA procedures and responsibilities.

Regulatory Flexibility Statement

The proposed recodification with amendments has been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendments impose no reporting, recordkeeping or other compliance requirements on small businesses; therefore, a regulatory flexibility analysis is not required. The rules govern a public assistance program designed to certify eligibility for the Aid to Families with Dependent Children program to a low-income population by a governmental agency, rather than a private business establishment.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10:81-2.6 Eligibility factors other than need

(a)-(c) (No change.)

(d) Rules concerning Social Security numbers are as follows:

1. The AFDC applicant shall supply the CWA with the Social Security number of each member of the eligible unit or apply for

a Social Security number for any such person who does not already have one (see (d)3 and 5 below).

2. The IM worker shall record, in the appropriate spaces on FAMIS Form 105 and Form PA-1J (Application and Affidavit for Public Assistance), the Social Security number of each person who is included in the AFDC assistance payment.

3. The CWA shall obtain a supply of Social Security Form SS-5, sufficient to accommodate all AFDC applicants (with the exception of illegal aliens) and eligible individuals who do not already have Social Security numbers. Upon application for AFDC, the applicant shall be required to sign as many SS-5 forms as needed for the eligible family. The IM worker shall complete Form SS-5 on the basis of information provided by the applicant. Completed forms shall be forwarded to the county's respective Social Security Administration District Office (SSA/DO). A copy of the SS-5 form shall be retained in the case record, and a copy given to the client is so requested.

i. The IM worker shall record in the case record the date upon which Form SS-5 was prepared.

ii. If any applicant refuses to provide or apply for the appropriate Social Security number(s), the CWA shall declare such person ineligible for AFDC benefits. The needs of that individual shall be deleted in accordance with N.J.A.C. 10:82-2.4.

(1) For a "newborn" child, whose birth certificate may not be readily available, the completion of time for the SS-5 is extended to the first day of the second month after the birth of the child.

(2) A signed and certified hospital document may be accepted in lieu of a birth certificate, provided that it contains the same information that would appear on a birth certificate, that is, child's name, date of birth, place of birth, mother's name, mother's residence, and father's name.

iii. Public assistance applicants who are legal residents of the United States in accordance with the provisions of the U.S. Immigration and Naturalization Service (INS), but not United States citizens, shall have Form PA-55, County Welfare Agency Alien Referral to Social Security (SSA) District Office for Social Security Number Application, processed at the SSA/DO in order to be enumerated.

(1) For enumeration purposes, not all U.S. born individuals are U.S. citizens. These individuals may include former U.S. citizens who are now citizens of another country. Additionally, children of foreign diplomats or other temporary aliens who are born in the U.S. while their parents are in the U.S. are considered citizens of the parents' home country. Such individuals shall not be referred to the SSA/DO unless the individual is a legal U.S. resident as stated above.

(2) Form PA-55 is to be used to refer legal residents of the United States as determined by the Immigration and Naturalization Service, who are not U.S. citizens, to the SSA/DO. Liaisons in the SSA/DO have been instructed to return the bottom portion of that form to the specified CWA. For quality control purposes, the bottom portion of Form PA-55 is to be filed in the case record and will serve as acceptable documentation that the individual has applied for a Social Security number.

(3) Each CWA is to create a tickler file to monitor the flow of referral forms (PA-55s) and receipts of acknowledgement (bottom portions of Form PA-55). Immediately upon receipt of such acknowledgement, CWAs shall input the filing date of the SS-5 form on the 105 form, thereby providing tracking for the issuance of Social Security numbers, and file the acknowledgement in the case record.

iv. Inasmuch as applicants for AFDC-N need not be citizens or lawfully admitted aliens (see N.J.A.C. 10:81-3.10), illegal aliens cannot procure a Social Security number and are therefore exempt from this requirement.

4. Procedures for verifying Social Security numbers are as follows:

i. The CWA shall verify the Social Security numbers (SSNs) provided by the eligible family with the Social Security Administration (SSA) by submitting them through FAMIS. Benefits shall not be denied, delayed or terminated for an otherwise eligible family pending SSN verification. Once the SSNs have been verified, the CWA shall make a permanent annotation to the case file to prevent unnecessary reverification of the SSN in the future.

5. AFDC benefits shall not be denied, delayed or terminated pending issuance or verification of a Social Security number so long as the applicant/recipient has complied with the provisions of (d)1 through 4 above.

6. Every applicant for and recipient of Medicaid benefits is required to furnish a valid Social Security number to the CWA as a condition of eligibility for Medicaid. Any applicant or recipient who does not already have a Social Security number shall be required to apply for same. In addition, (d)2 through 5 above shall apply to Medicaid recipients.

(e) Rules concerning enumeration at birth are as follows:

1. Participating hospitals have entered into an agreement with the New Jersey Department of Health, Bureau of Vital Statistics to initiate the enumeration process for newborns while the parent is in the hospital at time of the birth. This process is undertaken through a program implemented by SSA entitled "Hospital Enumeration at Birth Project". This process is for the convenience of the parent and is optional.

2. If the service is available at the hospital and the parent elects to apply, the parent is given Form SSA-2853/OP4, "Message From Social Security", that bears the name of the newborn for whom SSN application has been made and the dated signature of an authorized hospital official.

3. If Form SSA-2853/OP4 contains the foregoing identifying information, it serves as satisfactory verification that the family has applied for a SSN on behalf of the newborn for AFDC purposes provided that other documentation is available to connect the child to the parent.

4. In instances of "enumeration at birth," the CWA worker will not need to complete Form SS-5, "Application for a Social Security Number Card," for the newborn. Block QM/92 on FAMIS Form 105B will be completed by utilizing the "888" coding option for the infant in such situations.

5. Parents who elect to enumerate their newborn child(ren) through this process are required to furnish the assigned SSN to the CWA when it is received. The CWA shall, however, request proof of receipt of the SSN after six months from the child's birth have lapsed or at time of the recipient's next redetermination, whichever occurs first. If an SSN has not been assigned to the newborn at that time, then the CWA shall complete the SS-5 form for such newborn.

6. If the family is unable to provide Form SSA-2853/OP4, then the child shall be enumerated by the CWA through completion of an SS-5 following current application procedures.

7. CWAs shall not contact hospitals to verify that a child was enumerated through those facilities.

10:81-3.4 Sources of evidence regarding eligibility

(a)-(d) (No change.)

(e) With respect to "enumeration at birth," the CWA shall request proof of receipt of the SSN after six months from the child's birth have lapsed or at time of the recipient's next redetermination, whichever occurs first. If an SSN has not been assigned to the newborn at that time, then the CWA shall complete the SS-5 form for such newborn.

10:81-11.2 Eligibility requirements

(a) In addition to the eligibility requirements contained in N.J.A.C. 10:81-3 and 5, requirements for AFDC eligibility shall include the following:

1. [Social Security numbers: Applicants for AFDC (all segments) must provide Social Security numbers for all persons for whom assistance is requested (see N.J.A.C. 10:81-11.3).] **(Reserved)**

2.-3. (No change.)

(b)-(d) (No change.)

10:81-11.3 [Social Security numbers] **(Reserved)**

[(a) The AFDC applicant shall supply the CWA with the Social Security number of each member of the eligible unit or apply for

a Social Security number for any such person who does not already have one (see (c) and (e) below).

(b) Recording the Social Security number: The IM worker shall record, in the appropriate spaces on FAMIS Form 105 and Form PA-1J (Application and Affidavit for Public Assistance), the Social Security number of each person who is included in the AFDC assistance payment.

(c) Obtaining a Social Security number: The CWA shall obtain a supply of Social Security Form SS-5, sufficient to accommodate all AFDC applicants and eligibile individuals who do not already have Social Security numbers. Upon application the applicant shall be required to sign as many SS-5 forms as needed for the eligible family. The IM worker shall complete Form SS-5 on the basis of information provided by the applicant. Completed forms shall be forwarded to the county's respective Social Security Administration District Office (SSA/DO). A copy of the SS-5 form shall be retained in the case record, and a copy given to the client if so requested.

1. Documentation of application for Social Security number: The IM worker shall record in the case record the date upon which Form SS-5 was prepared.

2. Failure to obtain Social Security number: If any applicant refuses to provide or apply for the appropriate Social Security number(s), the CWA shall declare such person ineligible. The needs of that individual shall be deleted in accordance with N.J.A.C. 10:82-2.4.

i. For a "newborn" child, whose birth certificate may not be readily available, the completion time for the SS-5 is extended to the first day of the second month after the birth of the child.

ii. A signed and certified hospital document may be accepted in lieu of a birth certificate, provided that it contains the same information that would appear on a birth certificate, that is, child's name, date of birth, place of birth, mother's name, mother's residence, and father's name.

3. Public assistance applicants who are not United States citizens shall have Form SS-5, Application for Social Security Number Card, processed at the SSA/DO in order to be enumerated.

i. Form PA-55, County Welfare Agency Alien Referral to Social Security (SSA) District Office for Social Security Number Application, is to be used to refer alien individuals to the SSA/DO. Liaisons in the SSA/DO have been instructed to return the bottom portion of that form to the specified CWA. For quality control purposes, the bottom portion of Form PA-55 is to be filed in the case record and will serve as acceptable documentation that the individual has applied for a Social Security number.

ii. Each CWA is to create a tickler file to monitor the flow of referral forms (PA-55s) and receipts of acknowledgement (bottom portions of Form PA-55). Immediately upon receipt of such acknowledgement, CWAs shall input the filing date of the SS-5 form on the 105 form, thereby providing tracking for the issuance of Social Security numbers, and file the acknowledgement in the case record.

(d) Procedures for verifying Social Security numbers are as follows:

1. The CWA shall verify the Social Security numbers (SSNs) provided by the eligible family with the Social Security Administration (SSA) by submitting them through the FAMIS. Benefits shall not be denied, delayed or terminated for an otherwise eligible family pending SSN verification. Once the SSNs have been verified, the CWA shall make a permanent annotation to the case file to prevent unnecessary reverification of the SSN in the future. Social Security numbers previously verified by another program participating in the Income Eligibility Verification System shall be acceptable to the CWA for AFDC/AFDC-related Medicaid participation.

(e) Benefits pending issuance or verification of a Social Security number: AFDC benefits shall not be denied, delayed, or terminated pending issuance or verification of a Social Security number so long as the applicant/recipient has complied with the provisions of (a) through (d) above.

(f) Social Security numbers and Medicaid: Every applicant for and recipient of Medicaid benefits is required to furnish a valid Social Security number to the CWA as a condition of eligibility for Medicaid. Any applicant or recipient who does not already have a Social Security number shall be required to apply for same by completing Form SS-5. In addition, (b) through (e) above shall apply to Medicaid recipients.]

CORRECTIONS

(a)

THE COMMISSIONER

Medical Clemency

Proposed Amendments: N.J.A.C. 10A:16-8.1, 8.2, and 8.3

Authorized By: William H. Fauver, Commissioner, Department of Corrections.

Authority: N.J.S.A. 30:1B-6 and 30:1B-10.

Proposal Number: PRN 1994-53.

Submit comments by February 17, 1994 to:
William H. Fauver, Commissioner
Department of Corrections
CN 863
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Corrections is proposing several amendments at N.J.A.C. 10A:16-8.1, 8.2, and 8.3 regarding medical clemency. At N.J.A.C. 10A:16-8.1, Eligibility requirements, current language will be deleted which specifies that an application for medical clemency may be made when adequate treatment is not available within the correctional facility. This proposed amendment reflects the medical practices that have been in effect for many years. In actual practice, when an inmate needs specific treatment, that treatment will be arranged for and provided to the inmate while he or she is under conditions of confinement and in the custody of the Department of Corrections. For example, routine medical diagnosis/treatment is provided to an inmate(s) at the parent correctional facility or at any one of the other correctional facilities. Specialty diagnosis/treatment, such as Magnetic Resonance Imagery (MRI) testing or emergency room care is provided at a medical facility that the Department of Corrections has a prior agreement with. Highly complex medical treatment or a sophisticated procedure such as open heart surgery is conducted at a community medical facility that provides the appropriate acute medical care. Hence, there are no cases in which adequate treatment is not available for incarcerated inmates.

At N.J.A.C. 10A:16-8.2, petitions for medical clemency should be forwarded to the Deputy Commissioner instead of the New Jersey State Parole Board and the language at this cite has been amended to reflect such.

At N.J.A.C. 10A:16-8.3(b), language will be added that specifies charted records, which can be voluminous, will only be obtained by the Superintendent if deemed necessary. Also, a current Medical Status Report, which includes the inmate's diagnosis, prognosis and a description of the continuing medical and nursing care, has been added as N.J.A.C. 10A:16-8.3(b) to the list of documents required. Since a Medical Status Report includes the correctional facility physician and consulting physician's prognosis and description of the continuing care, N.J.A.C. 10A:16-8.3(b)2 and 3 have been recodified as subparagraphs i and ii under the new N.J.A.C. 10A:16-8.3(b)2. N.J.A.C. 10A:16-8.3(b)2i and ii will also reflect a change that the correctional facility physician confirms the consulting physician's findings. For the purpose of clarification, N.J.A.C. 10A:16-8.3(c) has been referenced back to N.J.A.C. 10A:16-8.3(b).

Social Impact

The proposed amendments clearly define those documents needed by the Superintendent and Deputy Commissioner when medical clemency is being considered for an inmate. It is expected that some inmates may object to the deletion of the medical clemency eligibility requirement at N.J.A.C. 10A:16-8.1(a)3 which states that an application can be submitted when adequate treatment is not available within the correctional facility since this amendment narrows the scope of eligibility. However,

this eligibility requirement is no longer necessary since the Department of Corrections will arrange and provide whatever medical care is needed to the inmate.

Economic Impact

For many years, the Department of Corrections has been obligated to provide a full scope of diagnosis and treatment to inmates. The proposed amendments which will delete the eligibility requirement, that specifies medical clemency may be considered when adequate treatment is not available within the Department of Corrections, simply reflect the longtime practice of providing this full scope of medical care while the inmate is under conditions of confinement. Therefore, these proposed amendments do not alter medical expenditures nor do they impose any economic burden because additional funding is not required to implement or maintain these amendments. The financial resources to provide these medical services and/or medical clemency procedures are obtained by the Department of Corrections through the State budgetary process.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendments do not impose reporting, recordkeeping or other compliance requirements on small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments impact on inmates and the New Jersey Department of Corrections and have no effect on small businesses.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10A:16-8.1 Eligibility requirements

(a) Application for [Medical Clemency] **medical clemency** may be made in cases when the physician of the correctional facility has determined that an inmate's medical condition is such that:

1. (No change.)

2. Death is imminent; **or**

[3. Adequate treatment is not available within the correctional facility; or]

Recodify existing 4. as **3.** (No change in text.)

(b)-(d) (No change.)

10A:16-8.2 Petition for medical clemency

(a) (No change.)

(b) The inmate who wishes to apply for [Medical Clemency] **medical clemency** shall obtain and complete PETITION FOR EXECUTIVE CLEMENCY. The completed Form shall be forwarded to the Superintendent for submission to the [New Jersey State Parole Board] **Office of the Deputy Commissioner.**

(c) (No change.)

10A:16-8.3 Role of the Superintendent

(a) (No change.)

(b) The Superintendent shall obtain from the Medical Department a copy of the following:

1. Charted records**, if deemed necessary**;

2. **A current medical status report which includes:**

[2.]**i.** A letter from the **consulting** physician [of the correctional facility] which includes his or her [opinion on] **diagnosis and prognosis of** the inmate's medical condition and a description of the continuing **medical/nursing** care which will be required; and

[3.]**ii.** A letter from the [consulting] physician **of the correctional facility** confirming the opinion of the **consulting** physician [of the correctional facility].

(c) The Superintendent shall send the following to the Deputy Commissioner, Department of Corrections:

1. (No change.)

2. One copy of the medical material[, which includes treatment and care required if Medical Clemency is granted] **as outlined in (b) above**;

3.-4. (No change.)

INSURANCE

(a)

OFFICE OF THE COMMISSIONER

Notice of Public Hearing and Extension of Comment Period

Administration: Licensing

Public Adjusters' Licensing

Proposed New Rules: N.J.A.C. 11:1-37

Take notice that, in accordance with N.J.S.A. 52:14B-4, the Department of Insurance ("Department") will hold a **public hearing** regarding proposed new rules N.J.A.C. 11:1-37 which establish procedures by which persons may become licensed public adjusters in New Jersey. The hearing will be held as set forth below:

Wednesday, February 9, 1994 at 9:30 A.M.
Department of Insurance
Mary Roebling Building
Room 219-220
20 West State Street
Trenton, New Jersey 08625

The purpose of the hearing is to receive public comment from interested parties regarding whether proposed rules N.J.A.C. 11:1-37, which were published on December 6, 1993 in the New Jersey Register at 25 N.J.R. 5432(a) should be promulgated, amended or adopted. The hearing shall be conducted by a Hearing Officer designated by the Commissioner. The Hearing Officer shall make recommendations to the Commissioner in the form of a written report, which shall be issued no later than 30 days after the record is closed and shall be made public. A verbatim transcript of the hearing will be prepared by a certified stenographic reporter; copies of the transcript may be obtained by ordering them directly from the reporter at the hearing or thereafter.

At the beginning of the hearing, the Department will present a summary of the factual information regarding the rationale for the rule. Thereafter, interested parties may present oral comments and may direct questions about the proposed rule through the Hearing Officer. The Department reserves the right to limit oral comments and questions in either time or number in order to complete the hearing by 4:30 P.M. on the scheduled hearing date.

Take further notice that the Department is extending the deadline for the submission of written comments to February 9, 1994. Written comments shall be submitted to the Department at the following address:

Attention: Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625-0325

No provision is made in N.J.S.A. 52:14B-4g for written comments on the Hearing Officer's Report and they will not be accepted.

The Department requests that **persons who wish to present oral comments or questions** notify the Department of their intention no later than 12:00 noon, February 8, 1994, either by writing to the Department at the address set forth above or by calling (609) 984-3602. If it is necessary to limit oral comments at the hearing, preference will be given to persons who notified the Department on a first come, first served basis.

(a)

DIVISION OF ENFORCEMENT AND CONSUMER PROTECTION

Insurance Producer Standards of Conduct: Management of Funds Record Maintenance

Proposed Amendment: N.J.A.C. 11:17C-2.6

Authorized By: Samuel F. Fortunato, Commissioner, Department of Insurance.

Authority: N.J.S.A. 17:1C-6(e), 17:22A-1 et seq., and 17:46B-9.

Proposal Number: PRN 1994-52.

Submit comments by February 17, 1994 to:
Verice M. Mason, Assistant Commissioner
Legislative and Regulatory Affairs
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

The agency proposal follows:

Summary

This proposal would amend the rule concerning record maintenance and examination, and electronic recordkeeping for insurance producers. The amendment is proposed to resolve a recordkeeping conflict regarding title insurance. The proposed amendatory action is in response to the Department's experience in implementing and enforcing this record maintenance provision and the peculiarities of title insurance.

Specifically, the proposed amendment provides that N.J.S.A. 17:46B-9 will be applied, with respect to title insurance only, if the provisions of N.J.A.C. 11:17C-2.6(a) conflict with the statute. N.J.S.A. 17:46B-9 provides that certain title insurance records be maintained for 15 years, whereas N.J.A.C. 11:17C-2.6(a) currently requires the insurance producers to maintain records for five years. This amendment addresses the conflict between the statute and the rule.

Social Impact

The amendment is proposed to resolve a conflict between a title insurance statute (N.J.S.A. 17:46B-9) and a recordkeeping rule (N.J.A.C. 11:17C-2.6(a)). The amendment provides that where there is a conflict the statute will apply.

Economic Impact

The proposed amendment will not impose any economic impact on insurance producers or the Department. The amendment merely resolves any conflict between a statute (N.J.S.A. 17:46B-9) and a rule (N.J.A.C. 11:17C-2.6(a)) by stating that where a conflict does exist between the two, the statute shall apply. Since both the statute and the rule are currently in force, there are no new requirements.

Regulatory Flexibility Statement

The proposed amended rule will apply to "small businesses" as this term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These small businesses include insurance producers. However, there are no new recordkeeping and compliance requirements and thus no new cost. The amendment merely resolves any conflict between N.J.S.A. 17:46B-9 and N.J.A.C. 11:17C-2.6(2) as noted above. The amendment will not require these small businesses to hire the services of any professionals.

Full text of the proposal follows (additions indicated in boldface **thus**):

11:17C-2.6 Record maintenance and examination; electronic record keeping

(a) All required books and records of account, including bank records, shall be maintained for a period of five years after the termination of coverage. **With respect to title insurance only, to the extent that the provisions of this section are in conflict with N.J.S.A. 17:46B-9, the latter shall be deemed to apply.**

(b)-(c) (No change.)

(b)

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status

Proposed Amendments: N.J.A.C. 11:21-14.4, 14.5 and Parts 1 and 2 of Exhibit U of the Appendix to N.J.A.C. 11:21

Authorized By: Samuel F. Fortunato, Commissioner, Department of Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), 17B:27A-34 and 17B:27A-46.

Proposal Number: PRN 1994-60.

Submit written comments by December 29, 1993 to:
Verice M. Mason
Assistant Commissioner
Division of Legislative and Regulatory Affairs
New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, N.J. 08625

The agency proposal follows:

Summary

These amendments are being proposed in accordance with P.L.1993, c.162, §16. Section 16 generally provides that prior to the adoption of an intended action authorized by N.J.S.A. 17B:27A-17 et seq., the Commissioner shall publish notice of the intended action in three newspapers of general circulation, and mail it to those persons and entities specified in Section 16. The Commissioner further is required to forward the notice of intended action and detailed description to the Office of Administrative Law for publication in the New Jersey Register. All interested persons must be provided an opportunity of not less than 15 days from the date of notice to submit written comments. (The time period and manner by which written comment is to be submitted is set forth above in this notice.) The Commissioner may take final action on these proposed amendments immediately following the close of the comment period. The final action shall be effective on the date the amendments, as adopted by the Commissioner, are submitted to the Office of Administrative Law for publication in the New Jersey Register, or such later date as the Commissioner may establish pursuant to P.L.1993, c.162, §16(e).

In accordance with N.J.S.A. 17B:27A-34, every carrier that is a small employer carrier must be classified either as a reinsuring carrier or a risk-assuming carrier. The classification bears upon the degree to which a carrier is responsible for losses in the small employer health market, and whether the carrier may obtain any reimbursements for such losses through the Small Employer Health Benefits ("SEH") Program. Rules at N.J.A.C. 11:21-14 set forth the standards and procedures for becoming either a reinsuring or risk-assuming carrier.

The proposed amendments primarily are intended to clarify when the election to be a reinsuring or risk-assuming carrier becomes operative for purposes of determining when the carrier's statutory election period begins (if a reinsuring carrier) and determining when a carrier does or does not become responsible for some portion of the loss assessments, if any. In addition, many carriers did not file an election by the due date and therefore are deemed to have elected to operate as a reinsuring carrier pursuant to N.J.A.C. 11:21-14.4(a). Therefore the proposed amendments clarify the method of becoming a reinsuring carrier by default or failure to be approved as a risk-assuming carrier. The Department believes that these proposed amendments will make the administration of the SEH Program with respect to loss assessments simpler and more consistent.

The Department proposes to clarify the requirement that the risk-assuming application form be supported by a certification by an actuary that the carrier is not in a financially unsound condition. Currently, the language suggests a certification that is overly broad for an actuarial opinion, encompassing aspects of the company's operations typically not under the review of a company's actuary or outside actuarial firm. The proposed amendment narrows the scope of certification of the actuarial opinion.

The Department also proposes to clarify that the supporting group experience information should be broken out between group experience generally, and small employer group experience specifically. The current language leaves some ambiguity in this regard.

The proposed amendment to N.J.A.C. 11:21-14.4(a), (b) and (c) specifies how to determine the date applicable for defaults to reinsuring carrier status, and sets forth the operative date of any actual or deemed elections. (N.J.A.C. 11:21-14.4(a) applies to carriers that currently are small employer carriers and their classification in the initial statutory election period; N.J.A.C. 11:21-14.4(b) applies to carriers that will become small employer carriers at some future date; and N.J.A.C. 11:21-14.4(c) applies to small employer carriers when classified as reinsuring carriers.)

The proposed amendment to N.J.A.C. 11:21-14.5 redefines the actuarial certification of a company's financial condition, and clarifies that the group experience should be bifurcated.

Consistent with the foregoing proposed date determination clarifications, a similar clarifying amendment is being proposed for the Reinsuring Carrier Declaration form, Part 1 of Exhibit U of the Appendix to N.J.A.C. 11:21.

Additionally, appropriate return addresses are being proposed for both the reinsuring and risk-assuming declaration forms, Parts 1 and 2 of Exhibit U.

Social Impact

The Department anticipates little or no social impact from these proposed amendments. These amendments clarify date determinations, but otherwise do not significantly alter any carrier's current status. Some carriers that otherwise might have assumed they had defaulted to a five year reinsuring carrier status may be pleased to find that they have defaulted to a two year reinsuring carrier status instead, and thus, find operation in the small employer health market more palatable than originally presumed. However, it is unclear that any of these amendments will either entice or deter carriers to or from the small employer health market.

Economic Impact

Although it is premature to analyze any impact because the reformed small employer market is not yet operational, it is probable that for most carriers these proposed amendments will produce either no economic impact, or will produce a favorable economic impact by clarifying that current small employer carriers which elect to, or by default, become reinsuring carriers may apply again to become risk-assuming carriers within two years, and are not locked into the reinsuring classification for five years. No other economic impact is foreseen.

Regulatory Flexibility Statement

These proposed amendments do not impose any additional compliance, reporting or recordkeeping requirements on any regulated entity, eliminating the need for a regulatory flexibility analysis. The amendments clarify when the election to be a reinsuring or risk-assuming carrier becomes operative for certain purposes, narrow the scope of the actuarial opinion that accompanies the risk-assuming application form, clarify exactly how supporting group information should be broken out, specify how to determine the date applicable for defaults to reinsuring carrier status, and set forth the operative date of any actual or deemed elections.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

11:21-14.4 Declaration to be a reinsuring or risk-assuming carrier

(a) Every small employer carrier shall file a declaration with the Board and Commissioner on or before October 4, 1993 or within 30 days of the date that the Board files its Plan of Operation with the Commissioner for review, whichever date is later, stating whether the small employer carrier elects to operate as a risk-assuming carrier or a reinsuring carrier for purposes of compliance with the Program.

1.-2. (No change.)

3. Any small employer carrier that fails to file a timely declaration **shall be deemed to have submitted a declaration to be a reinsuring carrier on October 4, 1993 or the 30th day following the date that the Board submitted its Plan of Operation to the Commissioner, whichever date is later, for purposes of determining the statutory election period for that carrier.**

4. Any small employer carrier[, or] that is disapproved as a risk-assuming carrier[,] shall be deemed to have elected to operate as a reinsuring carrier **on October 4, 1993 or the 30th day following the date that the Board submitted its Plan of Operation to the Commissioner, whichever date is later, for purposes of determining the statutory election period for that small employer carrier.**

5. The statutory election period shall be deemed to begin on January 1, 1994.

(b) Every carrier that is not currently a small employer carrier but determines to become one, shall file, at least 90 days prior to issuing any small employer health benefits plans, a declaration with the Board and the Commissioner stating whether the carrier elects to operate as a risk-assuming carrier or as a reinsuring carrier for purposes of compliance with the Program.

1. Any such carrier that fails to file a timely declaration **shall be deemed to have elected to operate as a reinsuring carrier as of the date the carrier files policy forms or certification of utilization of small employer policy forms, as appropriate, with the Board and the Commissioner.**

2. Any such carrier[, or] that is disapproved as a risk-assuming carrier[,] shall be deemed to have elected to operate as a reinsuring carrier **as of the date the carrier elected to operate as a risk-assuming carrier.**

3. In any calendar year in which a carrier elects to operate, or is deemed to have elected to operate, as a reinsuring carrier:

i. If the date, or deemed date, of election is on or before June 30 of that year, the statutory election period shall be deemed to begin on January 1 of that calendar year.

ii. If the date, or deemed date, of election is on or after July 1 of that year, the statutory election shall be deemed to begin on January 1 of the immediately succeeding calendar year.

(c) A carrier operating as a reinsuring carrier which elects to operate as a risk-assuming carrier effective upon the expiration of the statutory election period applicable to the reinsuring carrier shall file a declaration with the Board and the Commissioner 90 days prior to the end of the applicable statutory election period stating that the carrier elects to operate as a risk-assuming carrier for purposes of compliance with the Program.

1. (No change.)

2. The election shall not be effective until approved by the Commissioner as provided in this subchapter, **except that all approved such risk-assuming elections shall relate back to January 1, if approval occurs subsequent to the end of the carrier's reinsuring statutory election period.**

3. (No change.)

11:21-14.5 Application to be a risk-assuming carrier

(a)-(b) (No change).

(c) Every carrier filing for risk-assuming carrier status shall complete in full the Risk-Assuming Application Form set forth in Exhibit U, Part 3 of the Appendix of this chapter, incorporated herein by reference.

1.-2. (No change.)

3. The Risk-Assuming Application Form shall be supported by an actuarial opinion setting forth the assumptions and methodologies used to determine and certify that the [carrier is not in a hazardous financial condition as set forth in N.J.A.C. 11:2-27] **carrier's portfolio is of good and sufficient value, liquidity and diversity to assure the carrier's ability to meet its outstanding obligations as they mature and that surplus is adequate in relation to the amount of liabilities.**

4. The Risk-Assuming Application Form shall be accompanied by a statement setting forth the carrier's group experience in New Jersey for the past three years, if any. If a carrier or its affiliated carriers have no New Jersey group experience, then the statement shall set forth the national experience of the carrier and its affiliate(s). The experience information shall include:

i.-ii. (No change.)

iii. The **respective** lapse rates of all group contracts and **of** small employer group contracts annually;

iv. The **respective** net earned premium for group contracts and **for** small employer group contracts annually;

v. The **respective** incurred claims for group contracts and **for** small employer group contracts annually;

vi.-vii. (No change.)
5. (No change.)
(d)-(e) (No change.)

APPENDIX

...

EXHIBIT U
PART 1
REINSURING CARRIER DECLARATION

(To be submitted to the SEH Program Board and the New Jersey Department of Insurance, **Division of Financial Examinations, 20 West State Street, CN-325, Trenton, New Jersey 08625-0325, Attn: SEH Declaration.**)

Information on Person Completing this Declaration

Name: _____

Title: _____

Address: _____

_____

Phone: _____ FAX: _____

_____

(Carrier Name) _____ elects to operate as a reinsuring carrier for purposes of complying with the Small Employer Health Benefits Program established pursuant to N.J.S.A. 17B:27A-17 et seq. In accordance with N.J.S.A. 17B:27A-35, this election shall be binding:

a. for two years from [the effective date of this election, set forth below,] **January 1, 1994** if this election is made, **or is deemed to have been made,** prior to October 5, 1993, or within 30 days of the date the SEH Board submitted its Plan of Operation to the Commissioner, whichever date is later, or

b. [for five years from the effective date of this election, set forth below,] if this election is made on or after October 5, 1993 or after the 30th day following the submission of the Plan of Operation by the SEH Board to the Commissioner, whichever date [is] **was** later, **for five years from January 1 of the calendar year in which this election is made, if made on or before June 30 of the calendar year, or for five years from January 1 of the calendar year following the year in which this election is made, if the election is made subsequent to June 30 in a calendar year.**

This election is to be effective [on (Month/Day/Year)] on behalf of the company(ies) named below only. (Attach additional pages as necessary and include NAIC numbers, if any.)

1. _____
2. _____
3. _____

_____ _____
Date Signature

EXHIBIT U
PART 2
RISK-ASSUMING CARRIER DECLARATION

(To be submitted to the SEH Program Board and the New Jersey Department of Insurance, **Division of Financial Examinations, 20 West State Street, CN-325, Trenton, New Jersey 08625-0325, Attn: SEH Declaration/Approval.**)

...

LAW AND PUBLIC SAFETY

(a)

OFFICE OF THE ATTORNEY GENERAL

Petitions for Rules

Proposed New Rules: N.J.A.C. 13:1D

Authorized By: Fred DeVesa, Acting Attorney General.
Authority: N.J.S.A. 52:17B-4d.
Proposal Number: PRN 1994-49.

Submit comments by February 17, 1994 to:
Mary L. Cupo-Cruz
Legal Affairs Director
Office of the Attorney General
CN 081
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Administrative Procedure Act ("the Act"), at N.J.S.A. 52:14B-4(f), authorizes interested persons to petition a State agency "to promulgate, amend or repeal any rule." The Act also directs State agencies to "prescribe the form for the petition and the procedure for the submission, consideration and disposition" of any such petition. N.J.A.C. 1:30-3.6(d) also requires that each agency prescribe by rule the form of a petition and the procedures for its submission. The Department of Law and Public Safety proposes the following rulemaking petition procedures to satisfy this mandate.

The Department of Law and Public Safety is composed of a number of agencies headed by the Attorney General, N.J.S.A. 52:17B-2. The Attorney General retains direct rulemaking authority in certain functional areas. In addition to the rulemaking authority exercised by the Attorney General, a number of agencies within the Department have been granted direct rulemaking authority by statute. The Department also contains a number of independent agencies which have been administratively assigned within the Department but that are not subject to the operational control of the Attorney General. The proposed new rules provide a mechanism for interested parties to petition for rulemaking in substantive areas in which the Attorney General exercises rulemaking authority. The proposed new rules also provide a procedure to petition agencies within the Department which have direct rulemaking authority but have not adopted similar petition rules. Petitions for rulemaking directed to specific agencies which have adopted petition rules would be governed by those rules. The proposed new rules apply only to those agencies within the Department which are subject to the supervision of the Attorney General.

The proposed new rules provide that all petitions must be in writing and contain the substance or nature of the rulemaking which is requested, the reasons for the request and the petitioner's interest in the request, and reference to the authority of the agency to take the requested action.

Within 15 days of receipt of a petition, the Department will file a notice, stating the name of the petitioner and the nature of the request, with the Office of Administrative Law for publication in the New Jersey Register.

The proposed new rules further require that the Department take action on the petition within 30 days of its receipt. The action taken may consist of either a denial of the petition; action upon the petition, which may include the initiation of a formal rulemaking proceeding; or referral of the matter to the appropriate agency within the Department for further deliberation.

Social Impact

The proposed new rules will have a positive social impact on the public by establishing procedures for the filing and consideration of rulemaking petitions.

Economic Impact

No direct economic impact on the general public is expected to result.

Regulatory Flexibility Analysis

The proposed new rules would apply to any member of the public seeking amendment, promulgation or repeal of Department rules, including "small businesses" as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Under the proposed rules, a small

business will have to file rulemaking petitions in accordance with the requirements of these rules. The proposed new rules do not impose reporting, recordkeeping or other requirements. The proposed new rules merely specify the procedure to be followed by any member of the public who chooses to petition the Department for rulemaking.

Full text of the proposed new rules follows:

CHAPTER 1D
PETITIONS FOR RULES

13:1D-1.1 Scope

This chapter shall apply to petitions submitted pursuant to N.J.S.A. 52:14B-4(f) for the promulgation, amendment or repeal of any rule by the Attorney General and by any agency within the Department of Law and Public Safety that is subject to the supervision of the Attorney General, including those agencies which have independent or delegated rulemaking authority but have not adopted a rule providing for a petition for rulemaking.

13:1D-1.2 Procedure for petitions

(a) Except as otherwise provided in Title 13 of the New Jersey Administrative Code, any interested person may petition the Attorney General, or any agency within the Department of Law and Public Safety which is subject to the supervision of the Attorney General, to promulgate, amend or repeal any rule of the Department of Law and Public Safety. Such petition must be in writing, signed by the petitioner, and must state clearly and concisely:

1. The full name and address of the petitioner;
2. The substance or nature of the rulemaking which is requested;
3. The problem or purpose which is the subject of the request;
4. The petitioner's interest in the request, including any relevant organization affiliation or economic interest;
5. The statutory authority under which the Attorney General, or agency within the Department of Law and Public Safety which is petitioned, may take the requested action; and
6. Existing Federal or State statutes and rules which the petitioner believes may be pertinent to the request.

(b) Petitions for the promulgation, amendment or repeal of a rule submitted pursuant to this chapter shall be addressed to:

Legal Affairs Director
Office of the Attorney General
Hughes Justice Complex
CN-081
Trenton, New Jersey 08625

(c) Any document submitted to the Department of Law and Public Safety which is not in substantial compliance with this section shall not be deemed to be a petition for rulemaking requiring further agency action.

13:1D-1.3 Procedure after receipt of petition

(a) Upon receipt of a petition by the Department of Law and Public Safety filed pursuant to N.J.A.C. 13:1D-1.2:

1. The petition shall be date stamped and logged; and
2. The petition shall be referred to the relevant Department division or other Department office as appropriate.

(b) Within 15 days of receipt of a petition, the Department shall prepare and file a notice of petition with the Office of Administrative Law in compliance with N.J.A.C. 1:30-3.6(a).

(c) Within 30 days of receipt of a petition, the Department shall mail to the petitioner and file with the Office of Administrative Law for publication in the New Jersey Register a notice of action on the petition in compliance with N.J.A.C. 1:30-3.6(b).

(d) The Department's action on the petition may include:

1. Denial of the petition;
2. Filing a notice of proposed rule or a notice of pre-proposal for a rule with the Office of Administrative Law; or
3. Referral of the matter for further deliberations, the nature of which shall be specified and which shall conclude upon a specified date. The results of these further deliberations shall be mailed to the petitioner and shall be submitted to the Office of Administrative Law for publication in the New Jersey Register.

(a)

DIVISION OF MOTOR VEHICLES

Special Registration Plates for Non-Profit Organizations

Proposed Amendments: N.J.A.C. 13:20-39.1, 39.2, 39.3, 39.5 and 39.9

Authorized By: Stratton C. Lee, Jr., Director, Division of Motor Vehicles.

Authority: N.J.S.A. 39:2-3 and 39:3-27.39.

Proposal Number: PRN 1994-58.

Submit written comments by February 17, 1994 to:

Stratton C. Lee, Jr., Director
Division of Motor Vehicles
Attention: Legal Services Office
225 East State Street
CN 162
Trenton, New Jersey 08666

The agency proposal follows:

Summary

This proposal brings N.J.A.C. 13:20-39, Special Registration Plates for Non-Profit Organizations, into conformity with P.L. 1989, c.49 and existing Division procedures regarding the issuance of special non-profit organization license plates to the members of service organizations when the initial order for such plates is for at least 175 of the organization's members in good standing.

N.J.A.C. 13:20-39.1(a) is amended to delete an unnecessary New Jersey Session Law statutory citation (P.L. 1987, c.374) from the rule. As amended, the rule specifies that N.J.S.A. 39:3-27.35 et seq. provides for the issuance of special motor vehicle registration plates to members of non-profit community, alumni or service organizations in this State which have been approved by the Director of the Division of Motor Vehicles.

The proposal amends the definition of the term "organization" in N.J.A.C. 13:20-39.2 to mean any non-profit association, group or organization with a membership in good standing of at least 500 persons or, in the case of a service organization, with a membership in good standing of at least 175 persons, which qualifies as a non-profit organization. This amendment conforms the rule to P.L. 1989, c.49 and to existing Division procedures with regard to service organizations.

N.J.A.C. 13:20-39.3(a)2 is amended to specify that an organization seeking approval from the Division pursuant to N.J.A.C. 13:20-39 to have special motor vehicle registration plates prepared for its members in good standing who wish to apply for them shall be composed of an active membership in good standing of at least 500 persons or, in the case of a service organization, an active membership in good standing of at least 175 persons. This amendment conforms the rule to P.L. 1989, c.49 and to existing Division procedures with regard to service organizations.

The proposal amends N.J.A.C. 13:20-39.5(a) to provide that upon seeking approval to have special plates prepared for its members who wish to apply for same pursuant to N.J.A.C. 13:20-39, an organization shall submit to the Division a list of the legal names, addresses, and current New Jersey registration plate numbers of its 500 or more members in good standing or, in the case of a service organization, of its 175 or more members in good standing, in alphabetical order by surname, who will be requesting the special motor vehicle registration plates if the Division approves the issuance of such plates. This amendment conforms the rule to P.L. 1989, c.49 and to existing Division procedures with regard to service organizations.

N.J.A.C. 13:20-39.9(b) is amended to provide that the initial order for special motor vehicle registration plates submitted to the Division by an approved organization on behalf of its members applying for such plates pursuant to N.J.A.C. 13:20-39 shall be for no less than 500 members of the organization in good standing or, in the case of a service organization, for no less than 175 members of the organization in good standing. The rule also specifies that the initial order shall be accompanied by a non-refundable fee representing the total cost of the initial order, which shall be determined by multiplying the number of sets of plates being ordered by the applicable fee for each set of such plates set forth in N.J.A.C. 13:20-39.9(a). The amendment of N.J.A.C. 13:20-39.9(b) con-

forms the rule to P.L. 1989, c.49 and to existing Division procedures with regard to the initial order for plates submitted by a service organization.

The proposal amends N.J.A.C. 13:20-39.9(g) by inserting the correct address at the Division of Motor Vehicles to be utilized by an organization member who, upon receipt of the special motor vehicle registration plates and replacement certificate of registration, surrenders his or her replaced license plates to the Division of Motor Vehicles by mail.

Social Impact

The proposed amendments of N.J.A.C. 13:20-39 are beneficial to the public in that they conform the rules which non-profit organizations must follow to have special license plates prepared on behalf of their members in good standing who wish to apply for same to P.L. 1989, c.49 and to existing Division procedures, thus providing accurate information to interested members of the public. The proposed amendments have no social impact upon the Division of Motor Vehicles.

Economic Impact

The proposed amendments do not affect the public economically because the cost of various special non-profit organization plates (which was established through the adoption of N.J.A.C. 13:20-39.9(a) in November, 1988) remains unchanged by the proposed amendments. Those members of non-profit organizations who qualify for and wish to apply for such plates must pay the applicable fee set forth in N.J.A.C. 13:20-39.9(a): $25.00 per each set of plates for members of an approved non-profit community organization; $50.00 per each set of plates for members of an approved non-profit alumni organization; and $15.00 per each set of plates for members of an approved non-profit service organization.

The Division of Motor Vehicles incur administrative costs in producing and issuing such special registration plates for members of non-profit organizations.

Regulatory Flexibility Statement

The proposed amendments have been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments impose no reporting, recordkeeping or other compliance requirements upon small businesses; therefore, a regulatory flexibility analysis is not required. The amendments bring the provisions of N.J.A.C. 13:20-39 into conformity with P.L. 1989, c.49 and existing Division procedures.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:20-39.1 Purpose

(a) [P.L. 1987, c.374 (]N.J.S.A. 39:3-27.35 et seq.[)] provides for the issuance of special motor vehicle registration plates to members of non-profit community, alumni or service organizations in this State which have been approved by the Director. This subchapter establishes the following:

1.-8. (No change.)

13:20-39.2 Definitions

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

...

"Organization" means any non-profit association, group or organization with a membership in good standing of at least 500 persons **or, in the case of a service organization, with a membership in good standing of at least 175 persons,** which qualifies as a non-profit organization.

...

13:20-39.3 Qualifications for organization approval; final decision; right to suspend approval

(a) An organization seeking approval from the Division pursuant to this subchapter to have special motor vehicle registration plates prepared for its members in good standing who wish to apply for them shall:

1. (No change.)

2. Be composed of an active membership in good standing of at least 500 persons **or, in the case of a service organization, an active membership in good standing of at least 175 persons;**

3.-4. (No change.)

(b)-(c) (No change.)

13:20-39.5 Certification of memberships

(a) Upon seeking approval to have special plates prepared for its members who wish to apply for same pursuant to this subchapter, an organization shall submit to the Division a list of the legal names, addresses and current New Jersey registration plate numbers of its 500 or more members in good standing **or, in the case of a service organization, of its 175 or more members in good standing,** in alphabetical order by surname, who will be requesting the special motor vehicle registration plates if the Division approves the issuance of such plates.

(b)-(c) (No change.)

13:20-39.9 Fees; plate ordering; authenticity of membership

(a) (No change.)

(b) The initial order for special motor vehicle registration plates submitted to the Division by an approved organization on behalf of its members applying for such plates pursuant to this subchapter shall be for no less than 500 members of the organization in good standing **or, in the case of a service organization, for no less than 175 members of the organization in good standing.** The initial order shall be accompanied by a non-refundable fee representing the total cost of the initial order, which shall be determined by multiplying the number of sets of plates being ordered by the applicable fee for each set of such plates set forth in (a) above.

(c)-(f) (No change.)

(g) Upon receipt of the special motor vehicle registration plates and replacement certificate of registration by an organization member, that member must surrender his or her replaced license plates within 10 days to the Division at any motor vehicle agency or State operated motor vehicle inspection station or by mail to:

[Division of Motor Vehicles
Bureau of Office Services
CN-016
Trenton, New Jersey 08666-0016]
Division of Motor Vehicles
CN 403
Trenton, New Jersey 08666-0403

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Turn Prohibitions

Route N.J. 52 in Cape May County

Proposed New Rule: N.J.A.C. 16:31-1.34

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-123 and 39:4-183.6.

Proposal Number: PRN 1994-61.

Submit comments by February 17, 1994 to:
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to establish a new rule at N.J.A.C. 16:31-1.34 concerning turning movements along Route N.J. 52 to effect "no left turn" and no "U" turn in the City of Ocean City, Cape May County.

The provisions of this new rule will improve the flow of traffic and enhance safety along the highway system.

This new rule is being proposed at the request of the City Council of Ocean City and as part of the Department's ongoing review of current conditions. The City Council of Ocean City adopted Resolution No. 93-92-97 on September 16, 1993, requesting that no left turn and no "U" turn movements be effected along the length of Route N.J. 52 between the City of Ocean City (Cape May County) and the City of Somers Point (Atlantic County). This was implemented as a result of dangerous conditions on the bridge and Causeway. The traffic investigation conducted by the Department's Bureau of Traffic Engineering and Safety Programs proved that the establishment of the turning movement restrictions along Route N.J. 52 in the City of Ocean City were warranted. Signs are required to notify motorists of the restrictions proposed herein.

Social Impact

The proposed new rule will establish turn restrictions along Route N.J. 52 in the City of Ocean City, Cape May County to improve traffic safety. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will bear the costs for the installation of the appropriate regulatory signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size, and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed new rule does not place any reporting, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexiblity Act, N.J.S.A. 52:14B-16 et seq. The proposed new rule primarily affects the motoring public and the governmental entities responsible for the enforcement of the rules.

Full text of the proposed new rule follows:

16:31-1.34 Route 52

(a) Turning movements on certain parts of State highway Route 52 described in this subsection are regulated as follows:

1. In the City of Ocean City, Cape May County:

i. No left turn in both directions within the corporate limits of the City of Ocean City between mileposts 0.0 to 1.90.

ii. No "U" turn in both directions within the corporate limits of the City of Ocean City between mileposts 0.0 to 1.90.

TREASURY-TAXATION

(a)

DIVISION OF TAXATION

Financial Business Tax

Proposed Readoption with Amendments: N.J.A.C. 18:8

Authorized By: Leslie A. Thompson, Director, Division of Taxation.

Authority: N.J.S.A. 54:10B-22.

Proposal Number: PRN 1994-55.

Submit comments by February 17, 1994 to:

Nicholas Catalano
Chief, Tax Services
Division of Taxation
50 Barrack Street
CN-269
Trenton, NJ 08646

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 18:8 expires on February 24, 1994. The Division of Taxation has reviewed these rules and has determined them to be necessary, reasonable, and proper for the purpose for which they were originally promulgated. The Division proposes to readopt these rules with certain substantive and technical changes. The proposal includes technical updates necessitated by the Taxpayers' Bill of Rights, P.L. 1992, c.175, approved December 10, 1992 and relating to interest payments. N.J.A.C. 18:8-4.5, 4.10 and 4.13 reflect the change to annual compounding of interest from daily compounding contained in the cited legislative change. The readoption includes a cross reference to the new rule on abatement of interest at N.J.A.C. 18:8-4.17. It includes a new rule N.J.A.C. 18:8-4.18, cross referencing the penalty and interest contained in the State Tax Uniform Procedure Law. The time limit for protest is extended from 30 to 90 days. N.J.A.C. 18:8-5.1. The refund statute of limitations has been extended from two to four years. The law also makes provision for interest on overpayments. N.J.A.C. 18:8-6.4.

The proposal also includes clarifications of N.J.A.C. 18:8-3.3(b), which deals with allocation of net worth through the one factor formula. The modifications on sourcing gross business receipts to financial business activity with the State applies only to the financial business tax and is not applicable to the corporation business tax. The change makes clear the significance of business origination in sourcing receipts from such business and which may not have been sourced otherwise by the statute at N.J.S.A. 54:10B-8. This would have a bearing on situations where a back office activity was carried on in New Jersey but the origination of the business receipts occurred outside the State.

Taxation of financial businesses in New Jersey commenced in 1946. The Financial Business Tax Law, N.J.S.A. 54:10B-1 et seq. (P.L. 1946, c.174) was enacted following the recommendations of the First Report of the Commission on State Tax Policy. This legislation was enacted because New Jersey was taxing national banks under N.J.S.A. 54:9-1 et seq. but no other entities or persons conducting a financial business in New Jersey, thereby creating a problem under the United States Constitution as well as Federal law, R.S. 5219 (12 U.S.C.A. 548).

By legislation, a corporation which did a financial business became subject to the Corporation Business Tax Act, N.J.S.A. 54:10A-1 et seq. Individuals, partnerships, etc. doing a financial business continued to be taxed by the Financial Business Tax Law.

The Financial Business Tax Law is administered by the Director of the Division of Taxation, Department of Treasury, State of New Jersey. The Division prepares and audits the returns and collects the tax. Revenue from the tax collected from each taxpayer is distributed one-half to the State, one-quarter to the county and one-quarter to the municipality in which taxpayer does a financial business.

The rate of tax is one and one-half percent (.015) upon a financial business's net worth less deductions. There is a minimum tax of $25.00.

Subchapter 1 delineates the taxpayers subject to tax, subchapter 2 the computation of tax, and subchapter 3 deals with allocation of net worth. Returns, payments and penalties are provided for in subchapter 4. Protests and appeals comprise subchapter 5. Subchapter 6 covers refunds, lien of tax and injunction. Subchapters 7 and 8 are reserved for future rules. Dissolution or liquidation of the taxpayer is covered in subchapter 9.

Social Impact

Individuals and partnerships are regulated by these rules. Their business activity is taxed because they are in a financial business. Due to the nature of the entities subject, this taxing law is the vehicle under which the Legislature desired them to be taxed when the taxation of banks was legislated under the Corporation Business Tax Act by P.L. 1975, c.171. This tax is a net worth tax at one and one-half percent (.015) upon taxable net worth. There is no tax on taxpayers' net income.

Economic Impact

During the fiscal year 1989, all financial businesses paid a total of $54,807 and in fiscal year 1990 paid $38,713. This readoption is necessary to continue the orderly collection of this revenue source.

The updates that are directly related to the taxpayer bill of rights do not have independent economic impact since they merely conform the present rules to the existing legislative scheme. The provision relating sourcing receipts from and by business origination as opposed to back office activities clarifies the broad wording of some existing language relating to apportioning income from multistate businesses. Any hypothetical revenue impact of this section would depend upon the domestic activities of a given multistate taxpayer. The rules are intended

to facilitate taxpayer compliance with their statutory requirements and hence to lower the resources necessary to be expended in the course of complying with the act.

P.L. 1993, c.295 was recently enacted. It repeals the financial business tax as of January 1, 1994.

Regulatory Flexibility Analysis

The rules proposed for readoption apply to small businesses as well as to businesses employing more than 100 people. The reporting, recordkeeping and other compliance requirements in the law are applied uniformly; any action to exempt taxpayers who may be small businesses as defined in the Regulatory Flexibility Act would not be in compliance with applicable statutes. The filing, apportionment, interest payment, and penalty requirements must be applied uniformly to all taxpayers and exceptions for small business taxpayers cannot be made under the rules.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 18:8.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

CHAPTER 8
FINANCIAL BUSINESS TAX [LAW]

18:8-3.3 Taxpayer doing business in more than one State; allocating value of net worth

(a) (No change.)

(b) [Where] **Except as may be otherwise provided by law where** a taxpayer is entitled to allocate, the gross items of receipts attributable to place of business situated within the State of New Jersey are deemed to include all **business** receipts [resulting] **generated or originated** from transactions made or solicited or services rendered by officers, employees, salesmen and other representatives who work in, or from, or attached to places of business situated within this State.

18:8-4.5 Extension of time; interest extensions

(a)-(b) (No change.)

(c) Where an extension of time to file a return has been granted and payment is made within the time fixed under the extension, any portion of the tax in excess of the amount paid by the original due date shall bear interest at the rate of nine percent per annum from the date the tax was originally due until the date of payment or December 8, 1987, whichever is earlier, and on and after December 9, 1987, at the annual rate of three percentage points above the prime rate, compounded daily from the date the tax was originally due until the date of payment, **and on and after July 1, 1993 at the annual rate of three percentage points above the prime rate assessed for each month or fraction thereof, compounded annually at the end of each year from the date the tax was originally due until the date of actual payment.**

(d) Where payment of the tax is made after the time fixed under the extension of time to file a return, any portion of the tax remaining unpaid shall bear interest at the rate of one and one-half percent per month or fraction thereof from the date the tax was originally due until the date of payment or December 8, 1987, whichever is earlier, and on and after December 9, 1987 at the annual rate of five percentage points above the prime rate, compounded daily from the date the tax was originally due until the date of payment, **and on and after July 1, 1993 at the annual rate of three percentage points above the prime rate assessed for each month or fraction thereof compounded annually at the end of each year from the date the tax was originally due to the date of actual payment.**

(e) Where the estimated tax remitted with the tentative return is less than 75 percent of the tax liability shown on the final return and less than the amount of tax paid for the preceding year, the unpaid portion of the tax in excess of the amount estimated and remitted shall bear interest at the rate of one and one-half percent per month or fraction thereof from the date the tax was originally due until the date of payment or December 8, 1987, whichever is earlier, and on and after December 9, 1987, at the annual rate of five percentage points above the prime rate, compounded daily from the date the tax was originally due until the date of payment, **and on and after July 1, 1993 at the annual rate of three percentage points above the prime rate assessed for each month or fraction thereof, compounded annually at the end of each year from the date the tax was originally due until the date of actual payment.**

18:8-4.6 Failure to file return or make payment when due

For the effect or failure to file a return or make payments when due, see [sections] **N.J.A.C. 18:8-**4.5 (Extension of time; interest extensions), [4.7 (Secrecy of returns) and 8.1 (Criminal penalties) of this chapter] **4.10 (Delinquent payments; interest) and 4.13 (Deficiency assessments; interest).**

18:8-4.10 Delinquent payments; interest

Any taxpayer who fails to pay the tax when due is subject to interest in addition to the tax at the rate of one and one-half percent per month or fraction thereof computed from the date the tax was originally due to the date of actual payment, **and on and after December 9, 1987, at the rate of five percentage points above the prime rate, compounded daily from the date the tax was originally due until the date of payment, and on and after July 1, 1993 at the rate of three percentage points above the prime rate assessed for each month or fraction thereof, compounded annually at the end of each year from the date the tax was originally due until the date of actual payment.**

18:8-4.13 Deficiency assessments; interest

(a) (No change.)

(b) In addition to the amount of any deficiency, the assessment or reassessment is subject to interest at the rate of one and one-half percent per month or fraction thereof, to be computed from the date the tax was originally due until the date of actual payment, **and on and after December 9, 1987 at the rate of five percentage points above the prime rate, compounded daily from the date the tax was originally due to the date of payment, and on and after July 1, 1993 at the rate of three percentage points above the prime rate assessed for each month or fraction thereof, compounded annually at the end of each year from the date the tax was originally due until the date of actual payment.**

18:8-4.17 Waiver of penalty and abatement of interest

(a) The Director may, for good cause shown, remit or waive:

1. (No change.)

2. The payment of any interest in excess of [3/4 of one percent per month.] **the rate of three percentage points above the prime rate. (See N.J.A.C. 18:2-2.7 for rules on abatements.)**

18:8-4.18 [(Reserved)] **Penalties**

Any taxpayer which shall fail to file its return when due or fail to pay any tax when due shall be subject to penalties and interest as provided for in the State Tax Uniform Procedure Law.

18:8-5.1 Protests, hearings; procedures

(a) Any taxpayer aggrieved by any finding or assessment of the director may, within [30] **90** days of the giving of notice thereof, file a protest in writing in the form and manner described in N.J.A.C. 18:1-1.8.

(b) (No change.)

18:8-6.3 Time limit for refund

All claims for refund must be filed with the Director within two years after the payment[s] of any original or additional tax assessed against the taxpayer. **For payments made on or after July 1, 1993, claims for refunds must be filed within four years after the payments of any original or additional tax assessed against the taxpayer.**

18:8-6.4 Payment of refunds; rejection of claims; **interest on overpayments**

(a) If upon examination of a claim for refund the Director determines that there has been an overpayment of the tax, the amount of overpayment **and the interest on the overpayment if any,** is credited against any liability of the taxpayer under any State tax law.

(b) If there is no liability the taxpayer is entitled to a refund of the tax overpaid **and the interest on the overpayment if any.**

(c) (No change.)

(d) For tax paid with respect to reports or returns due on or after January 1, 1994, interest will be paid on overpayments not refunded within six months after the last date prescribed, or permitted by extension of time, for filing the return or within six months after the return is filed, whichever is later. The interest will be paid at a rate determined by the Director to be equal to the prime rate, determined for each month or fraction thereof, compounded annually at the end of each year, from the date the interest begins to accrue to the date of the refund. The interest will begin to accrue on the later of the date of the filing by the taxpayer of the refund claim or requested adjustment, the date of the payment of the tax, or the due date of the report or return. No interest will be paid on an overpayment of less than $1.00.

(a)

DIVISION OF TAXATION

Public Utility Corporation Tax

Proposed Readoption with Amendments: N.J.A.C. 18:22

Authorized By: Leslie A. Thompson, Director, Division of Taxation.

Authority: N.J.S.A. 54:30-16 through 29, 54:30A-49 through 67, and 54:50-1.

Proposal Number: PRN 1994-56.

Submit written comments by February 17, 1994 to:

Nicholas Catalano
Chief, Tax Services
Division of Taxation
50 Barrack Street
CN-269
Trenton, NJ 08646

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 18:22 expires on February 24, 1994. The Division of Taxation has reviewed these rules and has determined them to be necessary, reasonable and proper for the purposes for which they were originally promulgated, as required by Executive Order No. 66(1978).

The first general tax act specifically taxing public utilities was enacted on April 18, 1884. Since that time, the tax rate and classification of property have been the subject of many statutory amendments. In 1940, the basic structure for the present tax law was adopted and the previous statutes repealed. The new law provided for both a franchise tax for the use of the public streets, highways, roads or other public places, and a gross receipts tax in lieu of a local tax on personal property. The franchise tax is measured by such portion of the taxpayer's gross receipts as the length of the lines or mains that are along, in, or over any public street, highway, road or other public place bears to the whole length of its lines. The gross receipts tax on certain corporations is in lieu of a local personal property tax; land and buildings are assessed and taxed locally. Chapters 4 and 5 of the Laws of 1940 substituted a uniform tax on public utilities which is administered by the State but all of the revenue, except the expenses of the State incurred in administering the taxes, is apportioned and paid directly to the municipalities.

P.L. 1991, c.184 altered the method of calculating public utility taxes for energy companies, as well as the schedule for payment of these taxes for energy companies and telecommunication companies. Primarily, the new law changed the tax on gas and electric light, heat and power corporations from a tax on gross receipts to a tax based on sales of units of therms of gas or kilowatt hours of electricity. Under a procedure specified by statute, the rate of taxation is to be calculated by the Board of Public Utilities, in consultation with the Division of Taxation. Additionally, the new law required payment of the taxes by April 1 of the current year for the affected companies.

Amendments to the rules adopted November 19, 1992 brought the rules into conformance with the new statute. Further minor amendments are proposed with this readoption to bring certain descriptive terminology into closer agreement with the 1991 law. A general description of the 1991 law has been added to the Foreword, and a deadline for filing that was changed by the 1991 law has been corrected in the Appendix. N.J.A.C. 18:22-7.1 has also been amended to more accurately describe the statute as amended by the 1991 law.

The sharing of revenue produced by State-administered taxes with local governmental jurisdictions is a significant feature of State and local fiscal relations.

The Act for which these rules are promulgated is known as the Taxation of Certain Public Utilities Laws of 1940.

Subchapter 1 deals with definitions and general provisions. Returns by telephone, telegraph, messenger systems and certain interstate transmission systems are dealt with in subchapter 2. In subchapter 3 are rules governing the excise tax payable to the State by telephone, telegraph and messenger systems. The rules relating to franchise tax payable to municipalities by telephone, telegraph and messenger systems are set forth under subchapter 4. Rules relating to apportionment of tax revenues from telephone, telegraph and messenger systems to municipalities are found in subchapter 5. Subchapter 6 deals with payment and collection of taxes payable to municipalities by telephone, telegraph and messenger systems. Subchapter 7 deals with gross receipts taxes imposed on sewerage and water corporations, and unit energy taxes imposed on gas and electric light, heat and power corporations. Returns, reports and statements and audit of returns of sewerage, water, gas and electric light, heat and power corporations are contained in subchapter 8. The excise tax payable to the State by sewerage, water, gas and electric light, heat and power corporations is covered in subchapter 9. Computation of taxes payable to municipalities by street railway, traction, sewerage, water, gas and electric light, heat and power corporations is covered in subchapter 10. Subchapter 11 deals with apportionment to municipalities of tax revenues from street railway, traction, sewerage, water, gas and electric light, heat and power corporations. Subchapter 12 deals with payment and collection of taxes payable to municipalities by street railway, traction, sewerage, water, gas and electric light, heat and power corporations. Subchapter 13 deals with water corporations and matters related to them. Appendix I deals with unit value to be applied against scheduled property and Appendix II contains a calendar of tax events.

Social Impact

Public utilities have been taxed since 1884. The nature of their business affects every member of the public who uses the services and products of the utility. The nature of their products and services are fundamental and necessary for human life. The utilities use the public streets, highways, roads or public places. Their lines or mains are along, in or over any public street, highway, road or other public place. There is a uniform tax on public utilities which is administered by the State. These tax revenues are shared with local government jurisdictions. The taxation of these utilities is administered by the Division of Taxation through the Local Property and Public Utility Branch.

Economic Impact

P.L. 1991, c.184 was anticipated to increase State revenues by requiring payment of public utility taxes in the current calendar year rather than the subsequent year. The proposed modifications to the rules are designed to bring the rules into conformance with the legislative changes to the statutes and should therefore have no significant economic impact beyond that resulting from the referenced statutory changes.

The readoption of the Public Utility Tax Rules will provide for continued accurate filing of the reports and for payment of the applicable tax. It will assist in supplying the anticipated revenue for state budgetary purposes and additionally provide mechanisms for refunds of tax in appropriate situations.

The rules are intended to facilitate taxpayer compliance with their statutory requirements and hence to lower the resources necessary to be expanded in the course of complying with the statute.

Regulatory Flexibility Analysis

The rules proposed for readoption apply to all taxpayers subject to the public utility tax statutes, whether or not they are small businesses as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The readoption incorporates three minor amendments to reflect the terminology added to the public utility tax statutes by P.L. 1991, c.184. Any exemption for small businesses would not be in compliance with applicable statutes. The rules contain further specification of the requirements contained in the public utility tax statutes. The rules require the filing of returns, properly documented and certified where appropriate, in accordance with the rates and schedules contained in the chapter (see Summary for description of requirements). While the

services of an accountant or other professional may be utilized by a public utility corporation, such services are not required by the readopted rules of the amendments.

Full text of the readoption may be found in the New Jersey Administrative Code at N.J.A.C. 18:22.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated by brackets [thus]):

FOREWORD

The first general tax act specifically taxing public utilities was enacted on April 18, 1884. Since that time, the tax rate and classification of property have been the subject of many statutory amendments. In 1940 the basic structure for the present tax law was adopted and the previous statutes repealed. The new law provided for both a Franchise Tax for the use of the public streets, highways, roads or other public places, and a Gross Receipts Tax in lieu of a local tax on personal property. The Franchise Tax is measured by such portion of the taxpayer's Gross Receipts as the length of the lines or mains that are along, in or over any public street, highway, road or other public place bears to the whole length of its lines. The gross receipts tax on certain corporations is in lieu of a local personal property tax; land and buildings are assessed and taxed locally. Chapters 4 and 5 of the Laws of 1940 substituted a uniform tax on public utilities which is administered by the State but all of the revenue, except the expenses of the State incurred in administering the taxes, is apportioned and paid directly to the municipalities.

P.L. 1991, c.184 altered the method of calculating public utility taxes for energy companies as well as the schedule for payment of these taxes for energy companies and telecommunication companies. This Act changed the tax on gas and electric light, heat and power corporations from a tax on gross receipts to a tax based on sales of units of therms of gas or kilowatthours of electricity. Under a procedure specified by statute, the rate of taxation is to be calculated by the Board of Public Utilities in consultation with the Division of Taxation. Additionally, the new law requires payment of the taxes by April 1 of the current year for the affected companies.

The sharing of **revenue produced by** State-administered taxes with local governmental jurisdictions is a significant feature of State and local fiscal relations.

The Act for which these rules and regulations are promulgated is known as the Taxation of Certain Public Utilities Laws of 1940.

These rules and regulations, when not otherwise modified, are the statements of general applicability and continuing effect, which implement, interpret, or describe, the law or policy of the Division of Taxation. Any reference in these rules and regulations to the "Act" or the "Tax Act" refers to the Taxation of Certain Public Utilities as amended and supplemented (N.J.S.A. 54:30A-16 et seq.).

The Taxation of Certain Public Utilities Laws of 1940 is administered by the Division of Taxation through the Local and Public Utility Branch.

Regulation reference numbers have been designated according to the regulations issued by the Director, Division of Administrative Procedure, pursuant to L. 1968, c.410, for example, Reg. 18:22-1 refers to the section of the New Jersey Administrative Code and should be cited as N.J.A.C. 18:22-1.

18:22-7.1 Imposition of tax and exemption under Act

The Act imposes a tax, measured by gross receipts[,] on sewerage[,] **and** water[,] **companies and measured by units of energy on** gas and electric light, heat and power corporations using or occupying the public streets, highways, roads or other public places; and, for the exemption from taxation of the franchises, stock, and certain property of such corporations; and, for the taxation of certain of the property of the corporations not so exempted from taxation.

APPENDIX II

PUBLIC UTILITY TAX
CALENDAR OF TAX EVENTS

Pre-tax Year	
. . .	
[May] **April** 1. (On or before.)	Excise taxes payable to the State: The excise taxes payable to the State are due on or before this date. (See N.J.A.C. 18:22-3.3, 18:22-9.6, 9.7)

. . .

(a)

DIVISION OF TAXATION

Gross Income Tax
Credit for Excess Contributions
Reproposed Amendment: N.J.A.C. 18:35-1.17

Authorized By: Leslie A. Thompson, Director, Division of Taxation.

Authority: N.J.S.A. 54A:9-17(a).

Proposal Number: PRN 1994-39.

Submit comments by February 17, 1994 to:

Nicholas Catalano
Chief, Tax Services
Division of Taxation
50 Barrack Street
CN 269
Trenton, NJ 08646

The agency proposal follows:

Summary

This proposal supersedes a previous proposal and amends N.J.A.C. 18:35-1.17 to include information for employers and employees regarding the reporting of the Workforce Development Partnership Fund and Health Care Subsidy Fund contributions (see 25 N.J.R. 1957(a)). The previous proposal indicated that employers were required to separately report on form W-2 each employee's contributions to the Workforce Development Partnership Fund and the Health Care Subsidy Fund. While no comments were received on the previous proposal, the Division has subsequently determined that separately stating these contributions will not be necessary.

The Division recognizes that many payroll services and employers have already set up their payroll records to reflect the separate contributions made to the Workforce Development Partnership and Health Care Subsidy Funds. Consequently, although the Division prefers that these contribution amounts be combined on the Form W-2, the proposed amendment indicates that separately reported amounts are acceptable.

Employees who find that they have overpaid their contributions to the Workforce Development Partnership Fund and/or the Health Care Subsidy Fund will be entitled to claim a credit against gross income tax. Overpayments of contributions to these funds, unemployment insurance or disability benefits can be claimed as a credit by filing the NJ-2450 when filing the New Jersey gross income tax return. The requirement that the taxpayer file the NJ-2450 in duplicate has been removed.

Social Impact

The proposed amendment recognizes that, although the Division prefers that employers report the contributions to the Workforce Development and Health Care Subsidy Funds as a consolidated amount, some employers will be unable to do so. Consequently, employers may, in the alternative, report these contributions separately on Form W-2.

Economic Impact

This proposed amendment should have no specific impact, since it only provides guidance regarding an already existing reporting requirement.

Regulatory Flexibility Analysis

The proposed amendment imposes alternative requirements regarding the statement on Forms W-2 issued by employers of amounts withheld for contributions to the Workforce Development Partnership and Health Care Subsidy Funds. The proposed amendment applies to small businesses as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Any action to exempt employers who may be small

businesses would not be in compliance with the New Jersey Gross Income Tax Act. Therefore, the Division of Taxation has applied these provisions to employers uniformly.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

18:35-1.17 Credit for excess contributions

(a) Credit for excess amounts deducted and withheld as worker contributions for unemployment [and], disability insurance, **Workforce Development Partnership Fund and Health Care Subsidy Fund** shall be treated as follows:

1. Employers issuing a W-2 form to employees shall include on it:

i.-ii. (No change.)

iii. The **combined total** amount withheld for Workforce Development Partnership Fund **and Health Care Subsidy Fund** contributions **or, in the alternative, the separate amounts contributed to these funds**;

iv.-v. (No change.)

(b) (No change.)

(c) An individual claiming a credit against gross income tax for overpayment of unemployment, disability insurance [or], Workforce Development Partnership Fund **or Health Care Subsidy Fund** contributions shall claim such credit by including with his New Jersey 1040 or New Jersey 1040-NR a completed New Jersey Form 2450[, in duplicate]. A claim not received within two years after the end of the calendar year in which the contributions were deducted is void. Such claims are not applicable to withholdings made during calendar years prior to 1983.

Examples 1.-2. (No change.)

(d) (No change.)

OTHER AGENCIES

(a)

NEW JERSEY TURNPIKE AUTHORITY

Traffic Control

Proposed Amendments: N.J.A.C. 19:9-1

Authorized By: New Jersey Turnpike Authority, Herbert I. Olarsch, Director of Law.

Authority: N.J.S.A. 27:23-1 and 27:23-29.

Proposal Number: PRN 1994-62.

Submit comments by February 17, 1994 to:

Herbert I. Olarsch, Esq.
Secretary and Director of Law
New Jersey Turnpike Authority
P.O. Box 1121
New Brunswick, New Jersey 08903

The agency proposal follows:

Summary

Subsequent to and as a result of recent rulemakings and readoption of the Authority's rules, a number of unintended omissions have been discovered and the need for other minor revisions has been identified. (The Authority proposed to amend N.J.A.C. 19:9-1.9(a)12vi concerning the use of "tandem" trailers on the Turnpike to conform with new State and Federal requirements on February 16, 1993 at 25 N.J.R. 684(a), and promulgated this amendment July 6, 1993 at 25 N.J.R. 2906(c). Pursuant to Executive Order No. 66(1978), the Authority's rules were proposed to be readopted with amendments July 6, 1993 at 25 N.J.R. 2839(b) and were readopted with technical changes not requiring additional public notice and comment October 4, 1993 at 25 N.J.R. 4605(a).) This proposal corrects the omissions and makes the revisions described within.

N.J.A.C. 19:9-1.3 (prohibiting use of emergency flashing lights), 1.4 (prohibiting operation of vehicles against direction of traffic), 1.5 (prohibiting U-turns), 1.6 (prohibiting parking, standing and stopping) and 1.7 (prohibiting use of medial strip) each contain an exception allowing certain enumerated classes of vehicles (State Police vehicles, the Authority's maintenance and official vehicles, Authority-authorized towing and repair services, other vehicles discharging emergency functions and, with respect to N.J.A.C. 19:9-1.3 only, Turnpike contractors' vehicles) to be operated contrary these rules provided they do not create a hazard to other vehicles. Prior to the October 1993 readoption, contractors' private vehicles and other vehicles discharging emergency functions were excepted from these rules only when operated in the course of Turnpike-related duties. In the course of the readoption, the Turnpike-related duty requirement was inadvertently deleted. As a result, these sections as readopted could be read to permit all contractors' vehicles and emergency vehicles, even if not en route to a construction site or emergency on the Turnpike, to be operated contrary to these rules. Because emergency flashing lights, U-turns, driving against the flow of traffic, parking, stopping and standing on the Turnpike in non-emergency situations and driving on the medial strip all disrupt the normal and safe flow of traffic, the exception to these rules was and is intended to be limited to vehicles responding to and returning from incidents on the Turnpike. This proposed amendment would re-insert the Turnpike-related duty requirement into each of these sections. The intent is to clarify that emergency vehicles are excepted from these provisions only when responding to an incident on the Turnpike and that contractors can only use emergency flashing lights while en route to or from a Turnpike construction site.

For purposes of integration, N.J.A.C. 19:9-1.9(a)12 is proposed to be amended by moving the private utility, house-type vehicle length restrictions from the footnote to this section into subparagraph (a)12iii and by deleting the footnote. No substantive change is proposed or intended.

The July 1993 amendment to N.J.A.C. 19:9-1.9(a)12vi, concerning tandem or "double bottom" trailers inadvertently removed all prohibitions against tandem vehicles of any size while the amendment was intended only to remove the requirement that a permit be obtained for tandems, which could not under any circumstances exceed 28 feet six inches per trailer. See rule summary at 25 N.J.R. 684(a). This proposal would reestablish N.J.A.C. 19:9-1.9(a)12vi, such that tandem trailers with overall individual trailer length not exceeding 28 feet six inches would be permitted to use the Turnpike without a permit, while continuing to prohibit all tandem trailers in excess of that length.

N.J.A.C. 19:9-1.9(a)25 presently prohibits the operation of unarticulated buses exceeding 40 feet in length. State and Federal law now permit the operation of unarticulated buses up to 45 feet in length, and that many new buses are in fact 45 feet long. The increase in the length of newer unarticulated buses is due in part to wheelchair accessibility requirements associated with the Americans with Disability Act (ADA). The New Jersey Motor Bus Association requested that this subsection be revised to permit the operation of 45-foot unarticulated buses. Upon review, the Authority has found that the length of unarticulated buses has been increased without a corresponding increase in the distance between axles. Therefore, the Authority does not expect the increased length of unarticulated buses to have a measurable impact on turning radius or maneuverability. The Authority therefore believes that 45-foot buses will not negatively impact safety on the Turnpike. The Authority anticipates that increasing this length limit will encourage patronage by operators of 45-foot unarticulated buses and would be consistent with the goals of the ADA. It is therefore proposed that N.J.A.C. 19:9-1.9(a)25 be amended to permit the operation of 45-foot unarticulated buses.

N.J.A.C. 19:9-1.15 governs the transport of hazardous materials on the Turnpike. The Federal classification system for explosives referenced in this subsection (b) (49 C.F.R. Part 173) was recently revised, and the Authority proposes coordinated changes to the reference in this subsection.

Social Impact

The proposed amendments provide for the continued safe and efficient use, operation and administration of the New Jersey Turnpike. The rules affect all motorists using the Turnpike insofar as they are intended to increase safety by limiting unexpected maneuvers by emergency vehicles, prohibiting over-length tandem trailers, and updating explosives transportation requirements. The proposed amendments will thus further the activities of individuals and businesses who rely on the Turnpike as a means of access through the State of New Jersey. Further, the amendments would further the goals of the Americans with Disabilities Act and the Clean Air Act by encouraging the operation of newest model buses, thereby increasing the mobility of persons benefitted by the ADA and generally encouraging the operation and patronage of buses rather than single occupancy vehicles. By allowing new model unarticulated buses to use the Turnpike, local congestion as a result of such buses is expected to be less than if such buses were prohibited from the

Turnpike and forced to use local roads as alternate routes. These amendments are consistent with the Authority's legislative mandate to operate a modern express highway embodying every known safety device.

Economic Impact

The Authority finances its operations, including the construction and maintenance of facilities, through bonded indebtedness, toll revenue and concession income as required by its enabling legislation. The Authority meets the financial obligations created by its bonded indebtedness primarily through the collection of tolls. The proposed amendments will not affect any of the Authority's funding sources.

These amendments are not expected to impose any economic effect on the public or other State agencies. Further, by ensuring the safe and efficient movement of persons and goods on the Turnpike and through the State, the proposed amendments are expected to have a positive economic impact on both State and regional economies.

Regulatory Flexibility Analysis

The amendments would apply to all small businesses that use the Turnpike to transport persons and goods through New Jersey. The only anticipated negative impact may be the effect of N.J.A.C. 19:9-1.3 through 1.7 on small businesses that conduct towing, repair or private ambulance services, or construction contractors that qualify as small businesses, as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Insofar as all these small businesses were already subject to these operating restrictions prior to the readoption of this chapter in October 1993, no additional requirements are imposed on these companies that they have not already complied with without comment. The towing of vehicles not disabled on the Turnpike has been, and remains, prohibited on the Turnpike, so this clarification will not impact those services. Further, substantive rules regarding the control of traffic must be uniformly applied to all vehicles for the protection of the travelling public. By maintaining a facility which enables the expedient transport of goods and services into and through New Jersey, these rules ultimately inure to the benefit of small businesses utilizing the Turnpike. The rules do not impose any reporting, recordkeeping or other compliance requirements on small businesses, and will actually reduce compliance requirements on such businesses by permitting the operation of tandem trailers without a prior permit application and permitting operation of the newest model buses on the Turnpike.

Full text of the proposal follows (additions to the current rules indicated in boldface **thus**; deletions from the current rules indicated in brackets [thus]):

19:9-1.3 Traffic control

(a) (No change.)

(b) No vehicle shall operate an emergency flashing light of any color on the Turnpike except State Police vehicles, the Authority's maintenance and official vehicles, contractors' private vehicles while in the performance of authorized **Turnpike** duties, vehicles on the Turnpike for the purpose of furnishing authorized towing and other services to disabled vehicles, and all other vehicles performing emergency services, such as ambulances and fire engines, when they are properly in use in the performance of authorized **Turnpike** duties.

(c) (No change.)

19:9-1.4 Uniform direction of traffic

(a)-(b) (No change.)

(c) Excepted from the provisions of this section are State Police vehicles, the Authority's maintenance and official vehicles and vehicles authorized to furnish towing and other services to disabled vehicles on the Turnpike, and all other vehicles discharging emergency functions, such as ambulances and fire engines, when they are properly in use in the performance of authorized **Turnpike** duties; provided that no such excepted vehicles shall be operated against the normal flow of traffic or contrary to classification prohibitions so as to create a hazard to other vehicles.

19:9-1.5 "U" turns prohibited

(a)-(b) (No change.)

(c) Excepted from the provisions of this section are State Police vehicles, the Authority's maintenance and official vehicles and vehicles authorized to furnish towing and other services to disabled vehicles on the Turnpike, and all other vehicles discharging emergency functions, such as ambulances and fire engines, when they are properly in use in the performance of authorized **Turnpike** duties; provided however, that this exception shall be for the sole purpose of crossing from a traffic lane carrying vehicles in one direction to a traffic lane carrying vehicles bound in the opposite direction; and provided further, that no such excepted vehicles shall make such crossing so as to create a hazard to other vehicles.

(d) (No change.)

19:9-1.6 Parking, standing or stopping on Turnpike prohibited except in case of emergency

(a) No vehicle shall be parked, stopped, loaded or unloaded or allowed to stand on the Turnpike except where otherwise posted or expressly permitted by the Authority. Excepted from the provisions of this section while in the performance of assigned duties are State Police vehicles, the Authority's maintenance and official vehicles and vehicles authorized to furnish towing and other services to disabled vehicles on the Turnpike, and all other vehicles discharging emergency functions, such as ambulances and fire engines, when they are properly in use in the performances of authorized **Turnpike** duties, provided that no such excepted vehicles shall be stopped so as to create a hazard to other vehicles.

(b)-(j) (No change.)

19:9-1.7 Use of medial strip prohibited

The medial strip between the traffic lanes of the Turnpike shall not be used for driving upon any part thereof or for crossing between said lanes by vehicles or by persons on foot. Excepted from the provisions of this section are State Police vehicles, the Authority's maintenance and official vehicles and vehicles authorized to furnish towing and other services to disabled vehicles on the Turnpike, and all other vehicles discharging emergency functions, such as ambulances and fire engines, when they are properly in use in the performance of authorized **Turnpike** duties, provided that no excepted vehicle shall use the medial strip so as to create a hazard to other vehicles.

...

19:9-1.9 Limitations on use of Turnpike

(a) Use of the Turnpike and entry thereon by the following, unless otherwise authorized by the Authority, is prohibited:

1.-11. (No change.)

12. Vehicles or combinations of vehicles, including any load thereon, exceeding the following extreme overall dimensions[1] or weights:

i.-ii. (No change.)

iii. Length: semitrailer in excess of 53 feet in length when in a tractor-semitrailer combination, **private utility, house-type semitrailer or trailer with a length of any single vehicle in excess of 35 feet, private utility, house-type semitrailer and towing vehicle combination in excess of 45 feet and private utility, house-type trailer and towing vehicle combination in excess of 50 feet.**

iv.-v. (No change.)

vi. Notwithstanding the above limitations, no vehicle operated with a tandem trailer combination, commonly known as a "double bottom," with overall individual trailer length in excess of 28 feet 6 inches shall be operated on the Turnpike.

13.-24. (No change.)

25. Omnibuses exceeding [40] **45** feet in length, excluding bumpers, and articulated omnibuses exceeding 61 feet in length, excluding bumpers.

(b) (No change.)

[1No private utility, house-type semitrailer or trailer with a maximum length for a single vehicle of more than 35 feet, a maximum length for a semitrailer and its towing vehicle of more than 45 feet and a maximum length for a trailer and its towing vehicle of more than 50 feet shall be operated on the New Jersey Turnpike.]

19:9-1.15 Transportation of hazardous materials

(a) (No change.)

(b) The transportation or shipment on the Turnpike of radioactive materials or devices, and transportation of [Class A, B and C]

Division 1.1, 1.2, 1.3 and 1.4 explosives, as defined in Part 173 of the regulations of the United States Department of Transportation (49 CFR 173), shall be subject to the prior written approval of the Authority. All applications for such approval shall be made in writing addressed to the Director of Operations and shall provide, to the satisfaction of the Authority, that the shipment shall comply in all respects with the provisions of parts 171 to 178 and 397 inclusive of [the regulations] **such regulations** (49 CFR 171-178, 397).

(a)

CASINO CONTROL COMMISSION

Employee Licenses
U.S. Citizenship or Federal Authorization to Work
Proposed Amendment: N.J.A.C. 19:41-1.3

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.
Authority: N.J.S.A. 5:12-63c, 69a, 70a, 82, 84, 85, 89b, 90b, 91b, 92, 95:12, and 102b-c.
Proposal Number: PRN 1994-40.

Submit written comments by February 17, 1994 to:
Ruth S. Morgenroth, Counsel
Casino Control Commission
Tennessee and Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

Summary

The proposed amendment would prohibit casino licensees from hiring individuals who are not United States citizens unless they have been authorized to work in the United States.

Social Impact

When the State Legislature passed the Casino Control Act it expected that the development of casino gaming operations in Atlantic City would benefit the economies of Atlantic City, the Atlantic City region and the State of New Jersey in a number of ways, including providing increased job opportunities. The employment in the casino industry of persons who are not citizens of, or authorized to work in, the United States deprives the citizens of this State the job opportunities which the legalization of casino gaming was designed to create. The proposed amendments prohibiting casino licensees and applicants from hiring such persons furthers these objectives and is also consistent with Federal law.

Economic Impact

The proposed amendments will have little or no economic impact on casino licensees or applicants. To the extent that the proposed amendments open up additional jobs for legal residents of New Jersey and the region, it will have a beneficial effect on the income of these individuals.

Regulatory Flexibility Statement

The proposed amendments will not affect individuals or companies who would qualify as a small business. The rules affect only individuals seeking employment by the casino licensees and the casino licensees themselves, neither of which are defined as small businesses under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, no regulatory flexibility analysis pursuant to small business concerns is required.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

19:41-1.3 Employee licenses

(a) No natural persons shall be employed in the operation of a licensed casino or a casino simulcasting facility in a supervisory capacity or be empowered to make discretionary decisions which regulate casino or casino simulcasting facility operations or the management of an approved hotel unless he or she is over 18 years of age, **is a citizen of the United States or is authorized pursuant to Federal law to work in the United States**, and holds a current and valid casino key employee license authorizing employment in the particular position. The following positions, without limitation, shall require a casino key employee license:

1.-11. (No change.)

(b) No natural person shall be employed in the operation of a licensed casino or a casino simulcasting facility or in a position whose employment duties require of authorized access to restricted casino areas unless he or she is over 18 years of age, **is a citizen of the United States or is authorized pursuant to Federal law to work in the United States**, and holds a current and valid casino employee license authorizing employment in the particular position. The following positions, without limitation, shall require a casino employee license:

1.-8. (No change.)

(c) No natural person shall be employed to perform services or duties in the conduct of the business of an approved hotel which are not included within the definition of casino employee or casino key employee unless he or she **is a citizen of the United States or is authorized pursuant to Federal law to work in the United States and** holds a current and valid casino hotel employee registration. The following positions, without limitation, require a casino hotel employee registration:

1.-6. (No change.)

(b)

CASINO CONTROL COMMISSION

Applications
Casino Licensees
Persons Doing Business with Casino Licensees
Agreements to Do Business with Casino Licensees
Vendor Requirements
Casino Service Industry License Requirements
Proposd Repeals: N.J.A.C. 19:41-11.3 and 11.4
Proposed Amendment: N.J.A.C. 19:51-1.2
Proposed New Rules: N.J.A.C. 19:43-10.4 through 10.6, 19:51-1.2A and 1.2B
Proposed Recodifications with Amendments: N.J.A.C. 19:41-11.1 and 11.2 as 19:43-10.2 and 10.3

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.
Authority: N.J.S.A. 5:12-63c, 69a, 70c, 89a, 90a, 91a and 106.
Proposal Number: PRN 1994-41.

Submit written comments by February 17, 1994 to:
Antonia Z. Cowan
Senior Counsel
Casino Control Commission
Tennessee Avenue at the Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

Summary

This proposal recodifies rules presently at N.J.A.C. 19:41-11, Applications, to N.J.A.C. 19:43-10, Casino Licensees, Vendor Requirements, in order to improve the organization and accessibility of the rules involved. Similarly, the casino service industry license requirements in N.J.A.C. 19:51-1.2 are reorganized and clarified. Proposed amendment N.J.A.C. 19:51-1.2 will address gaming-related casino service industry license requirements. Proposed new N.J.A.C. 19:51-1.2A governs nongaming-related enterprises and new N.J.A.C. 19:51-1.2B sets forth rules regarding transactional waivers here-to-fore found at N.J.A.C. 19:51-1.2(h) and (i).

Proposed new N.J.A.C. 19:43-10.4 concerning junket enterprise registration is basically recodified from N.J.A.C. 19:41-11.1(c) through (e) with some revisions.

Proposed new rule N.J.A.C. 19:43-10.5 describes a standard to be applied to determine whether a transaction may be deemed exempt from the vendor registration filing requirements and also lists certain types of transactions that are deemed exempt from such filing requirements

considering the described standard. That list includes the following different categories of exemptions based on the proposed standard: exemptions based on the nature of the transaction; exemptions based on the nature of the enterprise providing the goods or services or transacting business with the casino licensee or applicant; and exemptions based on other regulation of the enterprise involved by the Act or Commission regulation.

Proposed new rule N.J.A.C. 19:43-10.6 clarifies the required information contained in a purchasing and disbursement report which is filed monthly by casino licensees and applicants. This information allows the Commission to determine whether a vendor is conducting regular and continuing business that would require licensure as a casino service industry.

Social Impact

The proposed new rules and amendments implement the legislative requirements for the Casino Control Commission to oversee casino licensees and applicants and casino service industries and their participation in the gaming industry. The proposed new rules, repeals and amendments only affect casino licensees, applicants and casino service industry enterprises. The new rules and amendments codify and expand current practice and no incremental impact on such licensees and applicants is anticipated.

Economic Impact

The adoption of the rules being recodified and minimally amended is not expected to change any material cost associated with the production of the purchasing and disbursement reports since that information is already being provided to the Commission.

The proposed new rules at N.J.A.C. 19:43-10.4 through 10.6 establishing the types of transactions exempt from vendor registration filings clarify the previously required purchasing and disbursement reports. The adoption of these rules would increase the number of transactions deemed exempt from such filings and therefore would reduce the administrative costs incurred in order to comply with vendor registration filing requirements.

Regulatory Flexibility Analysis

The proposed amendments, repeals and new rules affect casino licensees, applicants and casino service industry enterprises, some of which may be "small businesses" as defined in N.J.S.A. 52:14B-17. However, the new rules and amendments do not require new procedures or additional reporting but, rather, clarify previously required reporting and establishes types of transactions exempt from vendor registration filing requirements.

The proposed new rule at N.J.A.C. 19:43-10.5 will decrease the amount of paper work required of both casino licensees or applicants and any casino service industry involved which may be a small business. Therefore, the new rule is expected to have a beneficial effect on both large and small businesses through the reduction in administrative expenses.

Although N.J.A.C. 19:43-10.6 is proposed as a new rule, it codifies existing reporting practices and therefore imposes no new burden on those regulated. The information required by the amendments and new rules is considered basic information, necessary to accomplish the purposes of the Act and not so burdensome as to necessitate differing standards based on business size.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

[19:41-11.1]**19:43-10.2** Presentation of [the agreement] **agreement; termination clause**

(a) Each casino licensee **or applicant** shall be required, upon directive of the Commission, to present to and file with the Commission a fully signed copy of every written agreement and a precise written description of every other agreement, including the terms thereof and the persons involved therein and associated therewith, regarding either:

1.-2. (No change.)

[(b) Each applicant for a casino license, upon directive of the Commission, shall be required to present to and file with the Commission every agreement described in (a)1 and 2 above not likely to have been fully and completely performed in all respects by all parties prior to the issuance to the applicant of a casino license.

(c) Except as otherwise provided in (d) below, each casino licensee or applicant for a casino license shall file with the Commission no later than 20 calendar days following the formal offer and acceptance of an agreement a completed vendor registration form in a form as specified by the Commission for any enterprise which has not already had such form filed with the Commission on its behalf by any casino licensee or applicant for a casino license. Vendor registration shall be required for any enterprise which has entered an agreement which the Commission has determined is governed by subsection 104(b) of the Act and this section, regardless of whether any direct compensation is exchanged by the parties as a result of the agreement. Such agreements shall include, without limitation, any agreement pursuant to which a bus owner or operator agrees to transport passengers to the casino hotel facility of a casino licensee in exchange for an agreement by the casino licensee to provide the passengers with complimentary services or items upon arrival. Notwithstanding the foregoing, an incomplete vendor registration form shall be considered timely filed by the licensee or applicant in accordance with this subsection if:

1. The incomplete vendor registration form is substantially complete except for minor errors or omissions and is filed within 20 days following the formal offer and acceptance of the agreement; and

2. A revised vendor registration form, completed in accordance with a deficiency notice provided by the Commission, is filed within 10 days of service of notice or by the end of the 20 day period, whichever is later.

(d) Each casino licensee or applicant for a casino license shall, prior to its participation in any junket which involves one or more junket enterprises, file with the Commission a junket enterprise vendor registration form for each junket enterprise involved in such junket which has not already had a junket enterprise vendor registration form filed with the Commission on its behalf by any casino licensee or applicant for a casino license. This requirement shall apply regardless whether such junket enterprise has had a vendor registration form filed with the Commission on its behalf pursuant to (c) above for an agreement unrelated to junkets. A junket enterprise vendor registration form shall be completed and certified by the junket enterprise in a form specified by the Commission and submitted to the casino licensee or applicant participating in the junket. The casino licensee or applicant shall be required to certify, to the best of its knowledge, as to the accuracy of the information provided by the junket enterprise. Notwithstanding the foregoing, an incomplete junket enterprise vendor registration form shall be considered timely filed by the casino licensee or applicant in accordance with this subsection if:

1. The incomplete junket enterprise vendor registration form is substantially complete except for minor errors or omissions and is filed prior to the arrival of the junket at the casino hotel; and

2. A revised junket enterprise vendor registration form, completed in accordance with a deficiency notice provided by the Commission, is filed within 10 days of service of notice or prior to the arrival of the junket, whichever is later.

(e) Any failure of a casino licensee or applicant for a casino license to seasonably file any information required by subsection 104b of the Act or the regulations of the Commission shall be the basis for the Commission to pursue any remedy or combination of remedies provided for in the Act or the regulations of the Commission.]

[(f)](**b**) Each agreement with a casino licensee or applicant [for a casino license] governed by subsection 104(b) of the Act and this section, whether or not expressly included therein by the parties thereto, shall be deemed to include a provision for its termination without liability on the part of the casino licensee or applicant [for a casino license], or on the part of any qualified party to the agreement or any related agreement the performance of which is dependent upon such agreement, if the Commission shall disapprove thereof in accordance with subsection 104b of the Act and the regulations of the Commission.

[(g) Every submission required by this subchapter shall comply with all the provisions of the Act and regulations of the Commission relating to applications.]

[(h)](c) Except as otherwise provided in [this section] **N.J.A.C. 19:43-10.4 and 10.5**, no agreement with a casino licensee **or applicant** shall be either performed or in force or effect unless a written vendor registration form or junket enterprise [vendor] registration form describing the enterprise performing pursuant to such agreement is properly and seasonably filed with the Commission in accordance with subsection 104b of the Act and the regulations of the Commission **and the casino licensee or applicant has submitted a purchasing and disbursement report in accordance with N.J.A.C. 19:43-10.6.**

[19:41-11.2]**19:43-10.3** [Suitability] **Review** of [the agreement] **agreements**

(a) The Commission may review each agreement governed by N.J.A.C. [19:41-11.1] **19:43-10.2** [on the basis of] **to determine** the **following:**

1. The reasonableness of the terms of the agreement, including the terms of compensation[, and on the further basis of the];

2. The qualifications of the persons involved in and associated with the agreement in accordance with the standards enumerated in section 86 of the Act[. The], **after which the** Commission may [thereafter] make a finding as to the suitability of [the] **such** persons to be involved or associated with the casino licensee or applicant[.];

3. Whether any enterprise involved therein or associated therewith is providing or likely to provide goods or services to, or conducting or likely to conduct business with, a casino licensee or applicant, its employees or agents which requires casino service industry licensure pursuant to section 92 of the Act and N.J.A.C. 19:51-1.2 or 1.2A, in which case the Commission shall direct that a casino service industry license application be promptly filed by the enterprise; and

4. Whether any action is desirable or necessary to regulate, control or prevent economic concentration in any casino service industry or to encourage or preserve competition in any casino service industry in accordance with N.J.S.A. 5:12-1b(12) and N.J.A.C. 19:51-1.6.

(b) Whenever, pursuant to subsection 92c of the Act and the regulations of the Commission, the Commission has exempted any person involved in or associated with an agreement governed by N.J.A.C. [19:41-11.1] **19:43-10.2** from the casino service industry license requirement otherwise imposed by subsection 92(c), the Commission may in its discretion base its findings as to the suitability of the person to be involved or associated with the casino licensee or applicant upon the fact of such exemption.

(c) If the Commission shall disapprove of an agreement governed by N.J.A.C. [19:41-11.1] **19:43-10.2** or any person associated therewith, the Commission may by directive require the termination of such agreement or association or pursue any remedy or combination of remedies provided for in the Act or the regulations of the Commission. If such disapproved agreement or association is not thereafter promptly terminated as required by Commission directive, the Commission may pursue any remedy or combination of remedies provided for in the Act or the regulations of the Commission.

(d) No provision of this section shall in any way limit the duty and obligation of any enterprise to, on its own initiative, apply for a casino service industry or junket enterprise license.

19:43-10.4 Vendor registration; junket enterprise registration

(a) Except as otherwise provided in (b) below or N.J.A.C. 19:43-10.5, each casino licensee or applicant shall file with the Commission no later than 20 calendar days following the formal offer and acceptance of an agreement a completed vendor registration form as specified in N.J.A.C. 19:41-5.11 for any enterprise which has not already had such form filed with the Commission on its behalf by any casino licensee or applicant. Vendor registration shall be required for any enterprise which has entered an agreement which the Commission has determined is governed by subsection 104b of the Act and this section, regardless of whether any direct compensation is exchanged by the parties as a result of the agreement. Such agreements shall include, without limitation, any agreement pursuant to which a bus owner or operator agrees to transport passengers to the casino hotel facility of a casino licensee in exchange for an agreement by the casino licensee to provide the passengers with complimentary services or items upon arrival.

(b) Each casino licensee or applicant shall, prior to the arrival at the casino hotel of a junket which involves one or more junket enterprises, file with the Commission a junket enterprise registration form as specified in N.J.A.C. 19:41-5.12 for each junket enterprise involved in such junket which has not already had a junket enterprise registration form filed with the Commission on its behalf by any casino licensee or applicant. This requirement shall apply regardless whether such junket enterprise has had a vendor registration form filed with the Commission on its behalf pursuant to (a) above for an agreement unrelated to junkets. A junket enterprise registration form shall be completed and certified by the junket enterprise in a form specified by the Commission and submitted to the casino licensee or applicant participating in the junket. The casino licensee or applicant shall be required to certify, to the best of its knowledge, as to the accuracy of the information provided by the junket enterprise.

(c) Notwithstanding (a) and (b) above, an incomplete vendor registration form or junket enterprise registration form shall be considered timely filed by the licensee or applicant in accordance with this section if:

1. The incomplete registration form is substantially complete except for minor errors or omissions, and is timely filed pursuant to (a) or (b) above, as appropriate; and

2. A revised registration form, completed in accordance with a deficiency notice provided by the Commission, is filed:

i. For a vendor registration, within 10 days of service of notice or by the end of the 20 day period, whichever is later; or

ii. For a junket enterprise registration, within 10 days of service of notice or prior to the arrival of the junket, whichever is later.

19:43-10.5 Vendor registration exemptions

(a) The Commission may, upon the request of a casino licensee or applicant or on its own initiative, exempt a transaction from the vendor registration requirements in N.J.A.C. 19:43-10.4 if the Commission determines that vendor registration is not necessary to protect the public interest and further the policies set forth in sections 1(b)6, 1(b)9, 92 and 104 of the Act. In making such a determination the Commission shall consider, without limitation, the following:

1. The nature of the goods or services provided or the business transacted;

2. The nature of the enterprise providing the goods or services or transacting the business with the casino licensee or applicant; and

3. Whether such enterprise is otherwise regulated by the Act or Commission regulations.

(b) The following transactions shall be deemed exempt pursuant to (a) above unless vendor registration is otherwise directed by the Commission:

1. Contributions to non-profit charitable corporations or organizations, provided that no consideration is received for the contribution;

2. Direct payments to guests or guests and their representatives pursuant to a court order or stipulation of settlement or for settlement of guest losses or guest refunds;

3. Payments by the casino licensee or applicant for the following:

i. Payments for travel expenses incurred by an employee of the casino licnesee or applicant in the conduct of the employer's business including, without limitation, lodging, meals and transportation expenses;

ii. Payments to prospective employees for reimbursement of travel expenses incurred as a result of the employment interview; and

iii. Payments for training seminars, publication subscriptions, conference registrations or membership dues for professional associations that will directly contribute to the work performance or professional development of the employee;

4. Payments received from an employee of the casino licensee or applicant for purchases of obsolete hotel property or supplies for personal use;

5. Payments to government agencies for goods or services provided under statutory or other legal mandate, or for taxes, assessments, fines, garnishments or licensing fees and payments to public utilities having legal service monopolies;

6. Payments to or from individuals or enterprises pursuant to compliance with state or Federal law;

7. Payments by a third party manufacturer for rebates to a casino licensee or applicant for prior purchase of goods or services from licensed or registered vendors;

8. Payments for freight charges to freight transporters selected by the vendor for delivering goods C.O.D. or freight collect;

9. Transactions with travel industry enterprises that purchase or order lodging, meals, or other accommodations at a prededucted or gross commission rate which does not exceed 10 percent of cost;

10. Payments to unlicensed casino service industry applicants under transactional waivers approved pursuant to N.J.S.A. 5:12-92a and N.J.A.C. 19:51-1.2B;

11. Payments to any person required to qualify pursuant to N.J.S.A. 5:12-84b, 85c or 85e, which are a result of agreements pertaining to such person's status as a financial source or qualifer; and

12. Payments to labor organizations, unions and affiliates registered pursuant to N.J.S.A. 5:12-93 for employee dues and benefits programs.

19:43-10.6 Purchasing and disbursement reports

(a) Each casino licensee or applicant shall generate a master purchasing and disbursement report in accordance with this subsection for all transactions subject to N.J.S.A. 104b of the Act. Such report shall be submitted to the Commission on the Friday of the third full calendar week of each month by 5:00 P.M., unless that day is a State or Federal holiday, in which case the report shall be provided by 5:00 P.M. on the first weekday thereafter that is not a State or Federal holiday, and shall include the following information for the period since the most recent report was filed:

1. A payee register listing alphabetically by payee all non-payroll transactions drawn by the casino licensee or applicant and, at a minimum, the following information in tabular form next to the name of each payee:

i. Vendor identification number or exempt code;

ii. Amount of each individual disbursement;

iii. Date of each individual disbursement;

iv. Check number, or other identification of disbursement;

v. Subtotal of the disbursements by payee; and

vi. The grand total of all disbursements made during the reporting periods;

2. A manual attachment listing any transaction subject to this section which is not included in the payee register in (a)1 above or the magnetic computer tape in (a)6 below, including transactions with enterprises not yet assigned a vendor identification number, wire transfers and transactions by a subsidiary, intermediary company, holding company or agent of the casino licensee or applicant for goods or services that benefit the casino licensee or applicant. All transactions appearing on the manual attachment shall include, at a minimum, the following information:

i. Vendor name;

ii. Vendor identification number (if assigned) or exempt code;

iii. Date of disbursement;

iv. Amount of each disbursement; and

v. Subtotal of all disbursements;

3. A vendee register listing alphabetically by vendee all non-operating transactions in which the casino licensee or applicant was the vendor providing goods or services including, at a minimum, the following information in tabular form next to the name of the vendee:

i. Vendor identification number or exempt code;

ii. Date of each transaction;

iii. Amount of each transaction;

iv. Subtotal of all transactions; and

v. A general description of the type of good or service provided;

4. A voided check register listing alphabetically by vendor previously reported transactions that were subsequently voided or require corrected information and at a minimum, the following information:

i. Vendor name;

ii. Vendor identification number or exempt code;

iii. Date of original transaction;

iv. Amount of void; and

v. Date of void;

5. A subcontractor register listing all payments made to maintenance and construction companies performing services on the existing or proposed casino hotel or related facility, regardless of whether such company is a general contractor, subcontractor, secondary subcontractor or otherwise, including, at a minimum, the following the information:

i. Name and vendor identification number of each maintenance or construction company listed directly under the maintenance or construction company from which it received payment;

ii. Transaction dates;

iii. Dollar amount of each payment; and

iv. Monthly total dollar amount disbursed to each maintenance or construction company;

6. A magnetic computer tape listing all disbursements to enterprises appearing on the payee register (a)1 above and appearing on the subcontractor register (a)5 above, within specifications as required by the Commission, and a hard copy printout that includes the total number of transactions subject to the vendor registration filing requirements; and

7. The signature of the casino licensee's or applicant's chief operating officer or his or her designee verifying the accuracy of the information contained therein.

19:41-11.3 [Casino service industry license applications] **(Reserved)**

[(a) The Commission shall further review each agreement governed by N.J.A.C. 19:41-11.1 to determine whether any enterprise involved therein or associated therewith is a casino service industry enterprise required to be licensed by the Act and the regulations of the Commission.

(b) The Commission shall direct that a casino service industry license application be promptly filed by any enterprise involved in or associated with an agreement if the enterprise is providing or is likely to provide goods or services to, or is conducting or is likely to conduct business with a casino licensee, its employees or agents which directly relates to casino or gaming activity including, without limitation, a gaming school enterprise, a gaming equipment enterprise or a casino security service enterprise.

(c) The Commission shall determine each casino service industry license application filed pursuant to (b) above in accordance with the standards contained in subsections 92a and b of the Act and N.J.A.C. 19:43.

(d) The Commission shall direct that a casino service industry license application be promptly filed by any enterprise involved in or associated with an agreement if the enterprise is providing or is likely to provide goods or services to, or is conducting or is likely to conduct business, including junket business, with a casino licensee, its employees or agents on a regular or continuing basis which:

1. Is not directly related to casino or gaming activity; and

2. Has not been exempted from the casino service industry license requirement in accordance with subsection 92c of the Act and the regulations of the Commission.

(e) The Commission shall determine each casino service industry license application filed pursuant to (d) above in accordance with the standards contained in subsections 92c and d of the Act and N.J.A.C. 19:43; provided, however, that junket enterprises shall also be subject to the standards contained in section 102 of the Act and N.J.A.C. 19:49.

(f) The Commission, upon directing that a casino service industry license application be filed by any enterprise pursuant to (b) or (d) above, may also then indicate to the enterprise the amount of license fee in accordance with the provisions of the Act and the regulations of the Commission.

(g) The Commission may, in its discretion, permit a casino service industry enterprise which has been directed to file a license application pursuant to (d) above to continue, for a reasonable time, to

provide goods or services to or to conduct business with a casino licensee, its employees or agents. No casino licensee, or any employee or agent thereof, may purchase any goods or services from or engage in any business with an enterprise not holding a valid casino service industry license unless:

1. The casino licensee has generated a master purchasing and disbursement summary and an agreement filing system in a form approved by the Commission; and

2. A vendor registration form or junket enterprise vendor registration form had been filed with the Commission by a casino licensee on behalf of the enterprise doing such business in accordance with the provisions of N.J.A.C. 19:41-11.1; and

3. Any required casino service industry or junket enterprise license application has been properly filed by the enterprise with, and is pending before, the Commission; provided, however, that any enterprise directed to file an application may, in the discretion of the Commission, be permitted a reasonable time to prepare and file the application.

(h) In exercising the discretion established by (g) above, the Commission shall consider any relevant evidence or comments provided to it by the Division.

(i) The Commission may expressly prohibit any unlicensed enterprise from providing goods or services to or conducting business with a casino licensee, its employees or agents on the basis that, after having been directed to file a casino service industry or junket enterprise license application, such enterprise failed to properly file such application within a reasonable time. Any unlicensed enterprise prohibited from providing goods or services or conducting business on the basis of its failure to properly file an application may resume providing goods or services or conducting business:

1. Thirty days following the proper filing of its casino service industry or junket enterprise license application and after the payment of an additional late filing license fee of $250.00; or

2. Immediately following a determination that the enterprise is not required to be licensed as a casino service industry or junket enterprise.

(j) No waiver of all or any portion of the 30-day period mandated by (i)1 above shall be granted by the Commission on the ground of economic hardship or loss to the unlicensed casino service industry or junket enterprise in question.

(k) The application process for the approval of casino licensee agreements set forth in this subchapter shall not in any way limit the duty and obligation of any enterprise to, on its own initiative, apply for a casino service industry or junket enterprise license.]

19:41-11.4 [Competition within casino service industries] **(Reserved)**

[The Commission may further review each agreement governed by N.J.A.C. 19:41-11.1 to determine whether any action is desirable or necessary to regulate, control or prevent economic concentration in any casino service industry or to encourage or preserve competition in any casino service industry in accordance with N.J.S.A. 5:12-1b(12) and N.J.A.C. 19:43-1.6.

Editor's note: In addition to the text above, a sample application of a casino licensee for the approval of an agreement was adopted as a part of these rules but is not reproduced herein. Information on this form may be obtained from the Casino Control Commission, Arcade Building, Tennessee Avenue and Boardwalk, Atlantic City, NJ 08401.]

19:51-1.2 **Gaming-related casino service industry** [License] **license** requirements

(a) No enterprise shall provide goods or services directly related to casino, simulcast wagering or gaming activity to, or otherwise transact business directly related to casino, simulcast wagering or gaming activity with, a casino applicant or licensee, its employees or agents unless licensed in accordance with subsections 92a and b of the Act.

(b) In determining whether an enterprise shall be licensed pursuant to this [subsection] **section,** the Commission shall consider, without limitation, whether the enterprise satisfies one or more of the following criteria:

1. (No change in text.)

2. Whether the enterprise provides maintenance, service or repair pertaining to devices, machines, equipment, items, or articles governed by [(a)] **(b)**1 above; or

3.-4. (No change in text.)

[(b)]**(c)** (No change in text.)

19:51-1.2A Nongaming-related casino service industry and junket enterprise license requirements

[(c)]**(a)** Unless otherwise licensed in accordance with [(a) above] **subsections 92a and b of the Act and N.J.A.C. 19:51-1.2,** no enterprise shall, on a regular or continuing basis, provide goods or services regarding the realty, construction, maintenance[,] or business or a proposed or existing casino hotel or related facility[,] to a casino licensee or applicant, its employees or agents unless such enterprise is licensed or exempted in accordance with subsections 92c and d of the Act. [or authorized to do so pursuant to N.J.A.C. 19:41-11.3(g)] **The Commission may, however, permit the enterprise to continue to provide such goods and services or conduct such business if the application is prepared and filed within a reasonable time.**

(b) In determining whether an enterprise is subject to the requirements of this subsection, it shall not matter whether the casino licensee or applicant is a party to any agreement pursuant to which said goods or services are being provided. Enterprises **required to be licensed in accordance with subsections 92c and d of the Act and (a) above** [subject to the provisions of this subsection] shall include, without limitation, **the following:**

1. [suppliers] **Suppliers** of alcoholic beverages, food and nonalcoholic beverages, gaming table layouts[,] **and** non-value gaming chip sorters[,];

2. [in] **In**-State and out-of-State sending tracks[,];

3. [licensors] **Licensors** of authorized games to casino licensees and applicants[,];

4. [garbage] **Garbage** handlers, vending machine providers, linen suppliers[,] **and** maintenance companies[,];

5. [shopkeepers] **Shopkeepers** located within the approved hotel[,]; **and**

6. [limousine] **Limousine** services and construction companies contracting with casino licensees or applicants or their employees or agents.

[(d)]**(c)** No enterprise shall, on a regular or continuing basis, conduct business as a junket enterprise with a casino licensee or applicant, its employees or agents unless such enterprise is licensed in accordance with subsections 92c and d and section 102 of the Act. [or is authorized to do so pursuant to N.J.A.C. 19:41-11.3] **The Commission, however, may permit the enterprise to continue to conduct such business if the application is prepared and filed within a reasonable time.**

[(e)]**(d)** (No change in text.)

[(f)]**(e)** Notwithstanding the provisions of [(e)] **(d)** above, persons and enterprises which conduct business as a junket enterprise or provide, or imminently will provide, goods or services regarding the realty, construction, maintenance, or business of a proposed or existing casino hotel or related facility to casino licensees or applicants, their employees or agents shall, unless otherwise determined by the Commission, be deemed to be transacting such business on a regular or continuing basis if:

1.-4. (No change in text.)

5. The enterprise transacts business which satisfies either [(f)] **(e)** 3 or 4 above within each of three consecutive 12-month periods.

[(g)]**(f)** Based upon an analysis of the factors contained in [(e)] **(d)** above, the Commission may, in its discretion, require an enterprise which is otherwise governed by the provisions of N.J.S.A. 5:12-92c[, N.J.A.C. 19:41-11.3(g)] and [(c)] **(a)** above to be licensed as a subsection 92c casino service industry enterprise prior to conducting any business whatsoever with a casino licensee or applicant if the Commission determines that such action is necessary in order to contribute to the public confidence and trust in the credibility and integrity of the gaming industry in New Jersey. Enterprises subject to this requirement shall include manufacturers, suppliers

and distributors of gaming table layouts and non-value gaming chip sorters and licensors of authorized games to casino licensees and applicants.

[(h) Notwithstanding the provisions of (a) or (g) above, upon application for a transactional waiver by a casino licensee or applicant for each business transaction, the Commission may permit an applicant for a casino service industry enterprise license to conduct a business transaction with the casino licensee or applicant prior to the licensure of the casino service industry license applicant if:

1. A completed application for the appropriate casino service industry enterprise license required by (a) or (g) above has been filed by the applicant;

2. At least 30 days has elapsed since the filing of the completed application required by (h)1 above, unless the Division reports on an application for a transactional waiver prior thereto;

3. The Division does not object to the granting of the transaction waiver; and

4. The casino licensee or applicant shows good cause for granting the transactional waiver.

(i) The word "transaction", for the purpose of this section, shall be construed to effectuate the public interest and the policies of the Act.]

[(j)](g) In determining whether a person or enterprise has exceeded or will exceed the dollar thresholds established in [(f)] (e) above, all types of business, including junket business, transacted by that person or enterprise with casino licensees or applicants, their employees or agents shall be accumulated.

(h) The Commission may expressly prohibit any unlicensed enterprise from providing goods or services to or conducting business with a casino licensee or applicant, its employees or agents on the basis that, after having been directed to file a casino service industry or junket enterprise license application, such enterprise failed to properly file such application within a reasonable time. Any unlicensed enterprise prohibited from providing goods or services or conducting business on the basis of its failure to properly file an application may resume providing goods or services or conducting business:

1. Thirty days following the proper filing of its casino service industry or junket enterprise license application and after the payment of an additional late filing license fee of $250.00; or

2. Immediately following a determination that the enterprise is not required to be licensed as a casino service industry or junket enterprise.

(i) No waiver of all or any portion of the 30-day period mandated by (h)1 above shall be granted by the Commission on the ground of economic hardship or loss to the unlicensed casino service industry or junket enterprise in question.

19:51-1.2B Transactional waivers

(a) Notwithstanding N.J.A.C. 19:51-1.2(a) or N.J.A.C. 19:51-1.2A(f), upon application for a transactional waiver by a casino licensee or applicant for each business transaction, the Commission may permit an applicant for a casino service industry enterprise license to conduct a business transaction with the casino licensee or applicant prior to the licensure of the casino service industry license applicant if:

1. A completed application for the appropriate casino service industry enterprise license required by N.J.A.C. 19:51-1.2(a) or N.J.A.C. 19:51-1.2A(f) has been filed by the applicant;

2. At least 30 days has elapsed since the filing of such completed application, unless the Division reports on an application for a transactional waiver prior thereto;

3. The Division does not object to the granting of the transactional waiver; and

4. The casino licensee or applicant shows good cause for granting the transactional waiver.

(a)

CASINO CONTROL COMMISSION

Gaming Equipment
Rules of the Games
Pai Gow Poker
Automated Shuffling Devices and Dealing Shoes
Proposed Amendments: N.J.A.C. 19:46-1.13B and 1.19; 19:47-11.2, 11.4, 11.5, 11.6, 11.7, 11.8, 11.8A, 11.10 and 11.11
Proposed New Rules: N.J.A.C. 19:47-11.8B and 11.8C

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-69(e), 70(f), 99(a) and 100.

Proposal Number: PRN 1994-42.

Submit written comments by February 17, 1994 to:

Seth H. Briliant, Senior Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, N.J. 08401

The agency proposal follows:

Summary

The proposed amendments and new rules would permit a third type of dealing procedure to be used in the game of pai gow poker, as well as the use of an alternative method to select the first person to receive cards in the game. These changes to the authorized game of pai gow poker were suggested by ShuffleMaster, Inc., the manufacturer of an automatic card shuffler known as a "ShuffleMaster" and by several casino licensees, who wish to use the ShuffleMaster in the game of pai gow poker. The shuffler also contains an automated dealing shoe that dispenses cards in stacks of seven cards, instead of dispensing the cards singly as a manual dealing shoe does.

N.J.A.C. 19:46-1.19(c) does allow the use of an automatic shuffling and dealing device at specified table games, if the device and the procedures for shuffling and dealing the cards have been approved by the Commission. However, the way this device deals cards differs from the dealing procedures currently specified in N.J.A.C. 19:47-11.8 (cards are dealt individually in turn from a manual dealing shoe to each table position) and N.J.A.C. 19:47-11.8A (cards are dealt from the hand individually in turn into seven seven-card stacks, which are then delivered in sequence to each table position). New rule N.J.A.C. 19:47-11.8B would permit the proposed third dealing procedure, in which seven cards are dealt into a stack by an automated dealing shoe, and each stack is then delivered in sequence by the dealer. The proposed amendments to N.J.A.C. 19:47-11.11 address the various irregularities which could be caused by possible malfunctions of such an automated shuffling device or dealing shoe.

The ShuffleMaster also contains a computerized random number generator that selects and displays a number from 1 through 7. This device would be an alternate method of selecting the first person to receive cards in pai gow poker, which presently uses a shaker containing three dice. See N.J.A.C. 19:46-1.13B(e), 19:47-11.4(b) and 19:47-11.8C.

The ShuffleMaster is designed to shuffle one deck of cards for the next round of play while another deck of cards is being used for game play. Amendments to N.J.A.C. 19:47-11.2(b) and 11.5(d) would provide that two decks of cards may be used at a table where the ShuffleMaster is in use, as long as the back of each deck is a different color, and only one deck is being used for game play at any time.

In another change to current dealing procedures, N.J.A.C. 19:47-11.6 would be amended to clarify that the card-cutting procedure is not required when an automated card shuffling device such as the ShuffleMaster is being used. In the Commission's judgment, it is neither practical nor necessary to require a shuffled deck to be removed from a card shuffling machine to enable a player to cut the deck, only to have the dealer replace it in the machine so that the cards can then be dealt.

Finally, these amendments would streamline and recodify the present pai gow poker regulations. The present procedures for determining the first player to receive cards or a stack of cards would be recodified,

together with the new procedure for using a random number generator, as new rule N.J.A.C. 19:47-11.8C. The new rule would then be incorporated by reference in N.J.A.C. 19:47-11.8 and 11.8A, and in new rule N.J.A.C. 19:47-11.8B, as well as N.J.A.C. 19:47-11.10 (Player bank). Various provisions of N.J.A.C. 19:47-11.10, which duplicate existing sections N.J.A.C. 19:47-11.8, 11.8A and new rule 11.8B, would also be deleted; see N.J.A.C. 19:47-11.10(h)3 and 4, (i)5 and (j)3 and 4.

Social Impact

The proposed new dealing procedure should have no social impact beyond simply allowing casino licensees to deal the players' cards in a slightly different way.

The use of an automated card shuffler, an automated dealing shoe and a computerized random number generator to select the first dealing position in pai gow poker may result in a more efficient and a faster game. This change may stimulate additional interest in the game, which could benefit casino licensees, the general public, and the State, which would receive additional revenue from any increased play of the game of pai gow poker.

Economic Impact

If the devices and procedures permitted by these proposed rule amendments do result in a faster game, this could result in an economic benefit to casino licensees, and ultimately, to senior and disabled residents of New Jersey, after the initial expense of obtaining the necessary equipment has been satisfied. Since more hands could be played within the same period of time, additional casino and tax revenue would be generated. If the casinos, pursuant to this amendment, choose to use the shuffling devices, those engaged in the manufacture of the machines may realize increased business.

Regulatory Flexibility Statement

The proposed amendments and new rules will affect only New Jersey casino licensees, none of which is a "small business" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Accordingly, a regulatory flexibility analysis is not required.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

19:46-1.13B Pai gow poker table; pai gow poker shaker; physical characteristics; **computerized random number generator**

(a)-(c) (No change.)

(d) [Pai] **Except as provided in (e) below, pai** gow poker shall be played with a container, to be known as a "pai gow poker shaker," which shall be used to shake three dice before each hand of pai gow poker is dealt in order to determine the starting position for the dealing **or delivery** of the cards. The pai gow poker shaker shall be designed and constructed to contain any feature the Commission may require to maintain the integrity of the game and shall, at a minimum, adhere to the following specifications:

1.-2. (No change.)

(e) As an alternative to using the shaker and dice described in (d) above, a casino licensee may determine the starting position for the dealing or delivery of the cards in pai gow poker by utilizing a computerized random number generator that automatically selects and displays a number from 1 through 7 inclusive. Any computerized random number generator proposed for use by a casino licensee shall be approved by the Commission.

19:46-1.19 Dealing shoes

(a) (No change.)

(b) Cards used to game at blackjack, pai gow poker, minibaccarat and red dog shall be dealt from a **manual or automated** dealing shoe which shall be secured to the gaming table when the table is open for gaming activity and secured in a locked compartment when the table is not open for gaming activity. Cards used to game at baccarat shall be dealt from a **manual or automated** dealing shoe which shall be secured in a locked compartment when the table is not open for gaming activity. Notwithstanding the foregoing, cards used to game at pai gow poker may be dealt from the dealer's hand in accordance with N.J.A.C. 19:47-11.8A.

(c) A device which automatically shuffles cards may be utilized at the game of blackjack, pai gow poker, minibaccarat and red dog in addition to [or in place of] **a manual or automated** dealing shoe, provided that the **automated card shuffling** device and the procedures for [dealing and] shuffling **and dealing** the cards are submitted to and approved by the Commission.

(d) A **manual or automated** dealing shoe shall be designed and constructed to contain any feature the Commission may require to maintain the integrity of the game and, at a minimum, shall adhere to the following specifications:

1.-3. (No change.)

(e)-(g) (No change.)

19:47-11.2 Cards; number of decks[; dealing shoe]

(a) [Pai] **Except as provided in (b) below, pai** gow poker shall be played with one deck of cards with backs of the same color and design, one additional solid yellow or green cutting card and one additional solid yellow or green cover card to be used in accordance with the procedures set forth in N.J.A.C. 19:47-11.6. The deck of cards used to play pai gow poker shall meet the requirements of N.J.A.C. 19:46-1.17 and shall include one joker. Nothing in this section shall prohibit a casino licensee from using decks which are manufactured with two jokers provided that only one joker is used for gaming at pai gow poker.

[(b) All cards to be used in pai gow poker shall either be dealt from a dealing shoe which shall meet the requirements of N.J.A.C. 19:46-1.19 and shall be located on the table to the left of the dealer or dealt from the dealer's hand in accordance with the procedures set forth in this subchapter.]

(b) If an automated card shuffling device is used for pai gow poker, a casino licensee shall be permitted to use a second deck of cards to play the game, provided that:

1. Each deck of cards complies with the requirements of (a) above;

2. The backs of the cards in the two decks are of a different color;

3. One deck is being shuffled by the automated card shuffling device while the other deck is being dealt or used to play the game;

4. Both decks are continuously alternated in and out of play, with each deck being used for every other round of play; and

5. The cards from one deck only shall be placed in the discard rack at any given time.

19:47-11.4 [Dice; number of dice; pai] **Pai** gow poker shaker **and dice; computerized random number generator**

(a) Pai gow poker shall be played with three dice which shall be maintained at all times inside a pai gow poker shaker. The dice used to play pai gow poker shall meet the requirements of N.J.A.C. 19:46-1.15 and the pai gow poker shaker shall meet the requirements of N.J.A.C. 19:46-1.13B.

Recodify (b)-(c) as **1.-2.** (No change in text.)

(b) As an alternative to the pai gow poker shaker and dice described in (a) above, a casino licensee may, pursuant to N.J.A.C. 19:46-1.13B and 19:47-11.8C, play the game of pai gow poker with a computerized random number generator that automatically selects and displays a number from 1 through 7 inclusive.

19:47-11.5 Opening of the table for gaming

(a) After receiving [one] **a** deck of cards at the table in accordance with N.J.A.C. 19:46-1.18, the dealer shall sort and inspect the cards and the floorperson assigned to the table shall verify the inspection as required by N.J.A.C. 19:46-1.18. If the deck of cards used by the casino licensee contains two jokers, the dealer and a casino supervisor shall ensure that only one joker is utilized and that the other joker is torn in half and discarded.

(b)-(c) (No change.)

(d) If a casino licensee uses an automated card shuffling device to play the game of pai gow poker and two decks of cards are received at the table pursuant to N.J.A.C. 19:46-1.18 and 19:47-11.2, each deck of cards shall be separately sorted, inspected, verified, spread, inspected, mixed, stacked and shuffled in accordance with the provisions of (a) through (c) above immediately prior to the commencement of play.

[(d)]**(e)** All cards opened for use on a pai gow poker table and dealt from a **manual or an automated** dealing shoe shall be changed at least every eight hours. All cards opened for use on a pai gow

poker table and dealt from the hand shall be changed at least every four hours. Procedures for compliance with this subsection must be submitted to the Commission for approval.

19:47-11.6 Shuffle and cut of the cards

(a) Immediately prior to **the** commencement of play and after each round of play has been completed, the dealer shall shuffle the cards **either manually or by use of an automated card shuffling device** so that [they] **the cards** are randomly intermixed. **Upon completion of the shuffle, the dealer or device shall place the deck of cards in a single stack; provided, however, that nothing in this section shall be deemed to prohibit an automated card shuffling device which, upon completion of the shuffling of the cards, inserts the cards directly into an automated or manual dealing shoe.**

(b) After the cards have been shuffled **and stacked**, the dealer shall**:**

1. If the cards were shuffled using an automated card shuffling device, deal or deliver the cards in accordance with the procedures set forth in N.J.A.C. 19:47-11.8, 11.8A or 11.8B; or

2. If the cards were shuffled manually, cut the cards in accordance with the procedures set forth in (c) through (e) below.

(c) Upon completion of a manual shuffle, the dealer shall place the stack of cards on top of the cover card. Thereafter, the dealer shall offer the stack of cards to be cut, with the backs facing up and faces facing the layout, to the player determined pursuant to [(c)]**(d)** below. If no player accepts the cut, the dealer shall cut the cards.

Recodify (c) as **(d)** (No change in text.)

[(d)]**(e)** The player or dealer making the cut shall place the cutting card in the stack at least 10 cards from either end. Once the cutting card has been inserted, the dealer shall take the cutting card and all the cards on top of the cutting card and place them on the bottom of the stack. The dealer shall then remove the cover card and place it on the bottom of the stack. Thereafter, the dealer shall remove the cutting card and, at the discretion of the casino licensee, either place it in the discard rack or use it as an additional cutting card to be inserted four cards from the bottom of the deck. **The dealer shall then deal or deliver the cards in accordance with the procedures set forth in N.J.A.C. 19:47-11.8, 11.8A or 11.8B.**

[1. If the cards are to be dealt from a dealing shoe pursuant to N.J.A.C. 19:47-11.8, the cards shall then be inserted into the dealing shoe for commencement of play.

2. If the cards are to be dealt from the dealer's hand pursuant to N.J.A.C. 19:47-11.8A, the cards may be held by the dealer in either hand. Once the dealer has chosen the hand in which he or she will hold the cards, the dealer must use that hand whenever holding the cards. The cards held by the dealer shall at all times be kept in front of the dealer and over the table inventory container.]

[(e)]**(f)** [If] **Whenever** there is no gaming activity at [the] **a** pai gow poker table **which is open for gaming**, the cards shall be spread out on the table either face up or face down. If the cards are spread face down, they shall be turned face up once a player arrives at the table. After the first player is afforded an opportunity to visually inspect the cards, the procedures outlined in N.J.A.C. 19:47-11.5(c) shall be completed.

[(e) If there is no gaming activity at the pai gow poker table, the cards shall be spread out on the table either face up or face down. If the cards are spread face down, they shall be turned face up once a player arrives at the table. After the first player is afforded an opportunity to visually inspect the cards, the procedures outlined in N.J.A.C. 19:47-11.5(c) shall be completed.]

19:47-11.7 Wagers

(a)-(b) (No change.)

(c) All wagers at pai gow poker shall be placed prior to the dealer announcing "No more bets" in accordance with the dealing procedures set forth in N.J.A.C. 19:47-11.8, [or] 11.8A **or 11.8B**. No wager at pai gow poker shall be made, increased or withdrawn after the dealer has announced "No more bets."

19:47-11.8 Procedures for dealing the cards from a **manual** dealing shoe

(a) [Unless] **If** a casino licensee chooses to have the cards dealt from [the dealer's hand in accordance with the procedures set forth in this subchapter] **a manual dealing shoe, the dealing shoe shall meet the requirements of N.J.A.C. 19:46-1.19 and shall be located on the table to the left of the dealer.** [once] **Once** the [dealer has] **procedures required by N.J.A.C. 19:47-11.6 have been** completed [shuffling the cards and], the cards [have been] **shall be** placed in the **manual dealing** shoe[,] **and** the dealer shall announce "No more bets" [prior to shaking the pai gow poker shaker. The dealer shall then shake the pai gow poker shaker at least three times so as to cause a random mixture of the dice].

[(b) The dealer shall then remove the lid covering the pai gow poker shaker, total the dice and announce the total. The total of the dice shall determine which player receives the first card.

(c) To determine the starting position for dealing the cards, the dealer shall count counterclockwise around the table, with the position of the dealer considered number one and continuing around the table with each betting position counted in order, regardless of whether there is a wager at the position, until the count matches the total of the three dice. A casino licensee may in its discretion mark the first position to which cards will be dealt by use of an additional cut card or similar object. Examples are as follows:

1. If the dice total eight, the dealer would receive the first card; or

2. If the dice total 14, the sixth wagering position would receive the first card.]

(b) The dealer shall then, using one of the procedures authorized by N.J.A.C. 19:47-11.8C, determine the starting position for dealing the cards.

(c) After the starting position for dealing the cards has been determined, [(d) Each] **each** card shall be removed from the dealing shoe with the left hand of the dealer[,] and placed face down on the appropriate area of the layout with the right hand of the dealer. The dealer shall deal the first card to the starting position as determined in [(c)] **(b)** above and, moving clockwise around the table, deal **a card to** all other positions, including the dealer, [a card,] regardless of whether there is a wager at the position. The dealer shall then return to the starting position and deal a second card in a clockwise rotation and shall continue dealing until each position, including the dealer, has seven cards.

[(e)]**(d)** After seven cards have been dealt to each position [and], **including** the dealer, the dealer shall remove the remaining cards from the shoe and determine [that] **whether** exactly four cards are left.

1. If four cards remain, the four cards shall not be exposed to anyone and [they] shall be placed in the discard rack. The dealer shall then collect any cards dealt to a position where there is no wager and place them in the discard rack without exposing the cards.

2. (No change.)

[(f) Once seven cards have been dealt to each position and the dealer and any cards dealt to positions with no wagers have been collected, the dealer shall place the cover on the pai gow poker shaker and shake the shaker once. The pai gow poker shaker shall then be placed to the right of the dealer.]

19:47-11.8A Procedures for dealing the cards from the hand

(a) (No change.)

(b) [When dealing the cards from the hand, once the shuffle and cut of the cards have been completed, the] **If a casino licensee chooses to have the cards dealt from the dealer's hand, the following requirements shall be observed.**

1. Once the procedures required by N.J.A.C. 19:47-11.6 have been completed, the dealer shall place the deck of cards in either hand.

i. Once the dealer has chosen the hand in which he or she will hold the cards, the dealer shall use that hand whenever holding the cards during that round of play.

ii. The cards held by the dealer shall at all times be kept in front of the dealer and over the table inventory container.

2. The dealer shall **then** announce "No more bets" prior to dealing seven stacks of seven cards each to the area in front of the table

inventory container. The dealer shall deal each card by holding the deck of cards in [one of his or her hands] **the chosen hand** and [with] **using** the other hand [shall] **to** remove the top card of the deck and place it face down on the appropriate area of the layout.

(c) (No change.)

(d) After seven stacks of seven cards have been dealt, the dealer shall determine [that] **whether** exactly four cards are left by spreading them face down on the layout. [The]

1. If four cards remain, the cards shall not be exposed to anyone at the table and shall [then] be placed in the discard rack.

2. If more or less than four cards remain, the dealer shall determine if the cards were misdealt. If the cards were misdealt and a stack has more or less than seven cards, the round of play shall be void and the cards reshuffled. If the cards have not been misdealt, the round of play shall be considered void and the entire deck of cards shall be removed from the table pursuant to N.J.A.C. 19:46-1.18.

(e) Once the dealer has completed dealing the seven stacks and placed the four remaining cards in the discard rack, the dealer shall then [shake the pai gow poker shaker at least three times so as to cause a random mixture of the dice.

(f) The dealer shall then remove the lid covering the pai gow poker shaker, total the dice and announce the total. The total of the dice shall determine which player receives the first of the seven stacks. The stack farthest to the left of the dealer shall be considered the first stack and the stack farthest to the right of the dealer shall be considered the seventh stack.

(g) To determine the starting position for delivering the seven stacks, the dealer shall count counterclockwise around the table, with the position of the dealer considered number one and continuing around the table with each betting position counted in order, regardless of whether there is a wager at the position, until the count matches the total of the three dice. A casino licensee may in its discretion mark the first position to which a stack will be dealt by use of an additional cut card or similar object. Examples are as follows:

1. If the dice total eight, the dealer would receive the first stack; or

2. If the dice total 14, the sixth wagering position would receive the first stack.], **using one of the procedures authorized by N.J.A.C. 19:47-11.8C, determine the starting position for delivering the stacks of cards.**

(f) After the starting position for delivering the stacks of cards has been determined, [(h) The] **the** dealer shall deliver the first stack to the starting position as determined in [(g)] **(e)** above and, moving clockwise around the table, deliver the remaining stacks in order to all positions, including the dealer [position], regardless of whether there is a wager at the position. **In delivering the stacks, the stack farthest to the left of the dealer shall be considered the first stack, and the stack farthest to the right of the dealer shall be considered the seventh stack.** The dealer shall deliver [all stacks] **each stack** face down.

[(i)]**(g)** After the seven stacks have been delivered to each position, **including** [and] the dealer, the dealer shall collect any stacks dealt to a **player** position where there is no wager and place them in the discard rack without exposing the cards.

[(j) Once the seven stacks have been delivered to each position and the dealer and any stacks dealt to positions with no wagers have been collected, the dealer shall place the cover on the pai gow poker shaker and shake the shaker once. The pai gow poker shaker shall then be placed to the right of the dealer.]

19:47-11.8B Procedures for dealing the cards from an automated dealing shoe

(a) Notwithstanding any other provision of N.J.A.C. 19:46 or this chapter, a casino licensee may, in its discretion, choose to have the cards used to play pai gow poker dealt from an automated dealing shoe which dispenses cards in stacks of seven cards, provided that the shoe, its location and the procedures for its use are approved by the Commission.

(b) If a casino licensee chooses to have the cards dealt from an automated dealing shoe, the following requirements shall be observed.

1. Once the procedures required by N.J.A.C. 19:47-11.6 have been completed, the cards shall be placed in the automated dealing shoe.

2. The dealer shall then announce "No more bets" prior to the shoe dispensing any stacks of cards.

(c) The dealer shall then, using one of the procedures authorized by N.J.A.C. 19:47-11.8C, determine the starting position for delivering the stacks of cards.

(d) Once the starting position has been determined in accordance with (c) above, the dealer shall deliver the first stack of cards dispensed by the automated dealing shoe to that position. As the remaining stacks are dispensed to the dealer by the automated dealing shoe, the dealer shall deliver a stack in turn to each of the other positions, including the dealer, moving clockwise around the table, whether or not there is a wager at the position. The dealer shall deliver each stack face down.

(e) After the seven stacks of seven cards have been dispensed and delivered to each position, including the dealer, the dealer shall remove the remaining cards from the shoe and determine whether exactly four cards are left by spreading them face down on the layout.

1. If four cards remain, the cards shall not be exposed to anyone at the table and shall be placed in the discard rack.

2. If more or less than four cards remain, the dealer shall determine if the cards were misdealt. If the cards were misdealt and a stack has more or less than seven cards, the round of play shall be void and the cards reshuffled. If the cards have not been misdealt, the round of play shall be considered void and the entire deck of cards shall be removed from the table pursuant to N.J.A.C. 19:46-1.18.

(f) If the dealer determines the cards were dealt properly, the dealer shall then collect any stacks dealt to a position where there is no wager and place them in the discard rack without exposing the cards.

19:47-11.8C Procedure for determining the starting position for dealing cards or delivering stacks of cards

(a) In order to determine the starting position for the dealing of cards or the delivery of stacks of cards for the game of pai gow poker, a casino licensee may, in its discretion, use the procedure authorized in (b) or (c) below.

(b) The dealer shall shake the pai gow poker shaker and dice described in N.J.A.C. 19:47-11.4 at least three times so as to cause a random mixture of the dice.

1. The dealer shall then remove the lid covering the pai gow poker shaker, total the dice and announce the total.

2. To determine the starting position, the dealer shall count counterclockwise around the table, with the position of the dealer considered number one, and continuing around the table with each betting position counted in order, including the dealer, regardless of whether there is a wager at the position, until the count matches the total of the three dice.

3. Examples are as follows:

i. If the dice total 8, the dealer would receive the first card or stack of cards; or

ii. If the dice total 14, the sixth betting position would receive the first card or stack of cards.

4. After the dealing or delivery of the cards has been completed in accordance with the procedures set forth in N.J.A.C. 19:47-11.8, 11.8A or 11.8B, the dealer shall place the cover on the pai gow poker shaker and shake the shaker once. The pai gow poker shaker shall then be placed to the right of the dealer.

(c) The dealer may use a computerized random number generator approved by the Commission to select and display a number from 1 through 7 inclusive, and verbally announce the number. To determine the starting position, the dealer shall count counterclockwise around the table, with the position of the dealer considered number one, and continuing around the table with each betting position counted in order, including the dealer, regardless of

whether there is a wager at the position, until the count matches the number displayed by the random number generator.

(d) After the starting position for a round of play has been determined, a casino licensee may, in its discretion, mark that position by the use of an additional cut card or similar object.

19:47-11.10 Player bank; co-banking; selection of bank; procedures for dealing

(a)-(g) (No change.)

(h) If the cards are to be dealt from a **manual** dealing shoe, **the procedures set forth** in [accordance with] N.J.A.C. 19:47-11.8[, the following procedures] **and 11.8C** shall apply, **except as follows**:

1. [Once the dealer has announced "No more bets,"] **If a pai gow poker shaker and dice are being used to determine the starting position for the dealing of the cards,** the bank shall shake the pai gow poker shaker **three times pursuant to N.J.A.C. 19:47-11.8C(b) instead of the dealer.** It shall be the responsibility of the dealer to ensure that the bank shakes the pai gow poker shaker at least three times so as to cause a random mixture of the dice. Once the bank has completed shaking the pai gow poker shaker, the dealer shall remove the lid covering the pai gow poker shaker, total the dice and announce the total. The dealer shall always remove the lid from the pai gow poker shaker and if the bank inadvertently removes the lid, the dealer shall require the pai gow poker shaker to be covered and reshaken by the bank.

2. If a computerized random number generator is used to determine the starting position for the dealing of the cards, the device shall be operated in accordance with procedures approved by the Commission.

[2.]**3.** [To] **When counting the betting positions, including the dealer, to** determine the starting position for dealing the cards, the [dealer shall count counterclockwise around the table, with the] position of the banker, **instead of the dealer, shall be** considered number one [and continuing around the table with each betting position counted in order, including the dealer, regardless of whether there is a wager at the position, until the count matches the total of the three dice].

[3. Each card shall be removed from the dealing shoe with the left hand of the dealer, and placed face down on the appropriate area of the layout with the right hand of the dealer. The dealer shall deal the first card to the starting position as determined in (h)2 above and, moving clockwise around the table, deal all other positions including the dealer a card, regardless of whether there is a wager at the position. The dealer shall then return to the starting position and deal a second card in a clockwise rotation and shall continue dealing until each position including the dealer has seven cards.

4. After seven cards have been dealt to each position and the dealer, the dealer shall remove the remaining cards from the shoe and determine that exactly four cards are left.

i. If four cards remain, the four cards shall not be exposed to anyone and shall be placed in the discard rack. The dealer shall then collect any cards dealt to a position where there is no wager and place them in the discard rack without exposing the cards.

ii. If more or less than four cards remain, the dealer shall determine if the cards were misdealt. If the cards were misdealt and a player or the dealer has more or less than seven cards, all hands shall be void pursuant to N.J.A.C. 19:47-11.11. If the cards have not been misdealt, all hands shall be considered void and the entire deck of cards shall be removed from the table pursuant to N.J.A.C. 19:46-1.18.

5. Once seven cards have been dealt to each position and the dealer and any cards dealt to positions with no wagers have been collected, the dealer shall place the cover on the pai gow poker shaker and shake the shaker once. The pai gow poker shaker shall then be placed to the right of the dealer.]

(i) If the cards are to be dealt from the hand, **the procedures set forth** in [accordance with] N.J.A.C. 19:47-11.8A **and 11.8C**[, the following procedures] shall apply, **except as follows**:

1. Once the dealer has completed dealing the seven stacks and placed the four remaining cards in the discard rack pursuant to N.J.A.C. 19:47-11.8A, the bank shall select the first stack to be delivered by the dealer. This stack shall be designated as the first stack by the dealer moving it toward the players.

2. [Once the first stack has been selected in accordance with (i)1 above,] **If a pai gow poker shaker and dice are being used to determine the starting position for the delivery of the first stack,** the bank shall shake the pai gow poker shaker **three times pursuant to N.J.A.C. 19:47-11.8C(b) instead of the dealer.** It shall be the responsibility of the dealer to ensure that the bank shakes the pai gow poker shaker at least three times so as to cause a random mixture of the dice. Once the bank has completed shaking the pai gow poker shaker, the dealer shall remove the lid covering the pai gow poker shaker, total the dice and announce the total. The dealer shall always remove the lid from the pai gow poker shaker and if the bank inadvertently removes the lid, the dealer shall require the pai gow poker shaker to be covered and reshaken by the bank.

3. If a computerized random number generator is used to determine the starting position for the delivery of the first stack, the device shall be operated in accordance with procedures approved by the Commission.

[3.]**4.** [To] **When counting the betting positions, including the dealer, to** determine the starting position for delivering the seven stacks **of cards**, the [dealer shall count counterclockwise around the table, with the] position of the bank, **instead of the dealer, shall be** considered number one [and continuing around the table with each betting position including the dealer, counted in order, regardless of whether there is a wager at the position, until the count matches the total of the three dice].

[4.]**5.** The dealer shall deliver the first stack as determined in (i)1 above to the starting position as determined in **N.J.A.C. 19:47-11.8C and** (i)[3]**2 through 4** above. Thereafter, the dealer shall deliver the remaining stacks in a clockwise rotation beginning with the stack closest to the right of the first stack and proceeding until all stacks to the right of the first stack have been dealt and then moving to the stack farthest to the left of the dealer and proceeding left to right. If there are no stacks to the right of the first stack, the dealer will begin with the stack farthest to the left and proceed to the right. The dealer shall [deal all stacks facedown] **deliver each stack face down** to each position, including the dealer, regardless of whether there is a wager at the position.

[5. After the seven stacks have been delivered to each position and the dealer, the dealer shall collect any stacks dealt to a position where there is no wager and place them in the discard rack without exposing the cards.

6. Once the seven stacks have been delivered to each position and the dealer and any stacks dealt to positions with no wagers have been collected, the dealer shall place the cover on the pai gow poker shaker and shake the shaker once. The pai gow poker shaker shall then be placed to the right of the dealer.]

(j) If the cards are to be dealt from an automated dealing shoe, the procedures set forth in N.J.A.C. 19:47-11.8B and 11.8C shall apply, except as follows:

1. If a pai gow poker shaker and dice are being used to determine the starting position for the delivery of the first stack of cards dispensed by the automated dealing shoe, the bank shall shake the pai gow poker shaker three times pursuant to N.J.A.C. 19:47-11.8C(b) instead of the dealer. It shall be the responsibility of the dealer to ensure that the bank shakes the pai gow poker shaker at least three times so as to cause a random mixture of the dice. Once the bank has completed shaking the pai gow poker shaker, the dealer shall remove the lid covering the pai gow poker shaker, total the dice and announce the total. The dealer shall always remove the lid from the pai gow poker shaker and if the bank inadvertently removes the lid, the dealer shall require the pai gow poker shaker to be covered and reshaken by the bank.

2. If a computerized random number generator is used to determine the starting position, the device shall be operated in accordance with procedures approved by the Commission.

3. When counting the betting positions, including the dealer, to determine the starting position for delivering the stacks of cards

as they are dispensed by the shoe, the position of the bank, instead of the dealer shall be considered number one.

Recodify (j)-(n) as **(k)-(o)** (No change in text.)

19:47-11.11 Irregularities; invalid roll of dice

(a)-(l) (No change.)

(m) If an automated card shuffling device is being used and the device jams, stops shuffling during a shuffle, or fails to complete a shuffle cycle, the cards shall be reshuffled in accordance with procedures approved by the Commission.

(n) If an automated dealing shoe is being used and the device jams, stops dealing cards, or fails to deal all cards during a round of play, the round of play shall be void, and the cards shall be removed from the device and reshuffled with any cards already dealt, in accordance with procedures approved by the Commission.

(o) Any automated card shuffling device or automated dealing shoe shall be removed from a gaming table before any other method of shuffling or dealing may be utilized at that table.

(a)

CASINO CONTROL COMMISSION

Gaming Equipment

Dealing Shoes

Proposed Amendment: N.J.A.C. 19:46-1.19

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12(c), 69(a) and 99(a).

Proposal Number: PRN 1994-43.

Submit written comments by February 17, 1994 to:

Barbara A. Mattie
Chief Analyst—Operations
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, NJ 08401

The agency proposal follows:

Summary

The proposed amendment makes optional the use of a device on the front of the face plate of a pai gow poker dealing shoe used to preclude players from viewing the next card to be dealt.

As of January 19, 1993, the rules of pai gow poker were amended on an experimental basis, to permit the dealing of cards from the hand and were finally adopted as amended at 25 N.J.R. 1887(b), effective May 3, 1993. It is therefore reasonable that the protective device on the face plate is no longer necessary. Accordingly, the proposed amendments will permit casino licensees to choose a dealing shoe with or without the device on the front of the face plate for dealing cards at the game of pai gow poker.

Social Impact

There will be no social impact on the gaming public or the regulatory agencies. The cards will continue to be dealt in the same order, and therefore, the outcome of the game will remain the same. The proposed amendment simply gives the casino licensees the option not otherwise afforded by the current rule.

Economic Impact

No economic impact is anticipated as a result of the proposed amendment since it will permit either the use of dealing shoes currently authorized for other games or existing pai gow poker dealing shoes.

Regulatory Impact Statement

This amendment will only affect the operation of New Jersey casino licensees, and, therefore, will not impact on any business protected under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16, et seq.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

19:46-1.19 Dealing shoes.

(a)-(e) (No change.)

(f) A pai gow poker dealing shoe, in addition to meeting the requirements of (d) above, [shall] **may, in the discretion of the casino licensee,** also contain a device approved by the Commission on the front of the face plate so as to preclude the players from viewing the next card to be dealt.

(g) (No change.)

RULE ADOPTIONS

AGRICULTURE

(a)

STATE AGRICULTURE DEVELOPMENT COMMITTEE

Acquisition of Development Easements

Adopted Amendment: N.J.A.C. 2:76-6.11

Proposed: September 7, 1993 at 25 N.J.R. 3890(a), October 18, 1993, 25 N.J.R. 4697(a).

Adopted: December 16, 1993 by State Agriculture Development Committee, Arthur R. Brown, Jr., Chairperson.

Filed: December 22, 1993 as R.1994 d.43, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 4:1C-5f.

Effective Date: January 18, 1994.

Expiration Date: July 31, 1994.

Summary of Public Comments and Agency Responses:

COMMENT: The Hunterdon County Agriculture Development Board responded that it has reviewed the proposal and has no objections.

RESPONSE: The SADC acknowledges the Hunterdon CADB's position.

COMMENT: The Burlington County Agriculture Development Board expressed its position that the SADC utilize the sliding scale method of easement purchase funding and oppose the retention of the existing cost share funding formula as an option available to the counties. The Board's recommendation is based on the following:

1. By retaining the existing cost share formula and offering the sliding scale method, the limited State funding available will be used to acquire fewer overall acres of farmland per round. The Board based its conclusion on the assumption that the current State cost share will be held constant on relatively expensive farmland (those objecting to the sliding scale) and will be increased for the less expensive farmland easements. The Board believes this trend is in direct conflict with the ultimate goal of the program which is to preserve the greatest extent of quality farmland as possible.

2. The Board believes that the sliding scale method of funding would cultivate municipal cost share participation in the acquisition of development easements. According to SADC statistics (EP-11) only three counties have experienced municipal contribution, including Burlington, Hunterdon and Middlesex. The comments received opposing the sliding scale represented the idea that areas with higher land values could not continue to participate within the Easement Purchase Program if the current method of funding from the State was not maintained. It is interesting to note that a majority of the respondents which opposed the sliding scale method have made no municipal contribution toward the preservation of their farms. The Board believes that municipal contribution in these cases would provide for an additional funding source which would allow these communities to continue participation in the Easement Purchase Program. In addition, it has been our experience that municipal contribution has the positive effect of creating a sense of commitment to farmland preservation among the township planning board and township committee. This in turn encourages the development of land use and zoning ordinances that support the agricultural industry and protect the township's investment in farmland preservation.

3. The sliding scale funding method does not decrease the SADC cost share percentage below 60 percent until the easement value surpasses $9,000 per acre. It is important to recognize that the development value of land is a result of the desirability of the land to a developer. That desirability is to a great extent a result of public investment in roads, utilities, school and open space. In those areas where development values are high, the public has already paid to create a favorable development climate and is now asked to pay again in the elevated cost of the development easement.

4. The Burlington CADB believes that the sliding scale formula addressed the inherent ability of different counties and municipalities to contribute toward the cost of farmland preservation. In review of the opposing comments received by the SADC regarding the "sliding scale" the Burlington CADB examined the fiscal impacts on a municipality from deed restricting land. Using the average easement value based on the 1990-92 rounds, the average value of a single family residence, the number of single family residences and the total assessment of a municipality, the average cost per household can be determined. Further, using the amount per household, the direct tax burden assumed by residential property owners can be determined. Based on the Board's findings, counties with historically higher easement values have a significantly broader tax base and therefore a greater ability to contribute local cost share dollars. The Burlington CADB believes that the study recognized that the municipalities where easement values are higher have an increased amount of monies to be raised but that they also have an increased tax base, due largely in part to the commercial and industrial base within a community. Therefore, the more rural a municipality, the greater the tax burden affects the individual landowner. Those areas where the easement value is lower do not have the commercial/industrial base to ease the tax burden on the residents of the municipality. In conclusion, the Board is opposed to the proposed amendment that incorporates both funding methods. The Board believes that the public dollars raised to fund the Easement Purchase program should be spent in areas where the public has not already spent money to provide for development. The Board strongly urges the Committee to reconsider adopting only the sliding scale as the method for determining the cost share paid by the Committee.

RESPONSE: Although the SADC understands the comments provided by the Burlington CADB, it also recognizes that no other county agriculture development board expressed its opposition to the proposed amendment. In fact, the remaining comments received were supportive of the proposal.

The Board's point that the sole use of the sliding scale method of funding by the SADC would cultivate municipal cost share participation in the acquisition of development easements is not necessarily an absolute. In areas where development easements were more expensive and the SADC's cost share percentage is reduced, it may force the county to look to the municipality to share the cost to acquire a development easement. Although community financial support is recognized in the SADC's "Criteria for evaluating development easement application," the willingness or ability of a municipality to provide cost share assistance has been discretionary. The decision of a municipality to provide cost share funds for the purchase of a development easement should be determined by the CADB and not on the basis of what method of cost sharing is provided by the SADC.

The Board expressed the concern that the use of the existing cost share formula and offering the landowner's asking price method (sliding scale method) will result in a higher cost to the SADC and ultimately less acres being permanently preserved. The proposed amendment which states that the SADC shall provide the greater cost share percentage as calculated by the two methods was specifically introduced to address the various fiscal constraints encountered by the 16 participating counties. The actual increase in cost by the SADC is difficult to estimate. Although there will be a decrease in the total acres being permanently preserved, the positive aspects may result in the preservation of lands which may otherwise have been lost to nonagricultural development. More importantly, the SADC feels that the adoption of the proposed amendment provides an opportunity to evaluate the use of the two methods at the conclusion of the upcoming 1994 funding round.

The Board's final concern was that public dollars raised to fund the easement purchase program should be spent in areas where the public has not already spent money to provide for development. Under the State farmland preservation program, the State and county already have developed criteria which evaluate the effect of development on the long-term viability of farmland. Since those factors are already considered in existing regulations, it is not necessary to address them in this amendment.

COMMENT: The Sussex County Agricultural Development Board expressed its support for the incorporation of the sliding scale formula (landowner's asking price method). The CADB indicated that although this method of calculating the SADC's cost share percentage is unpopular in the central portion of the state where land values are higher, it would be most beneficial in counties such as Sussex. The CADB further

emphasized that the more rural counties (such as Sussex) have a smaller tax base and it is much more difficult to raise county and local support for cost sharing.

RESPONSE: The SADC acknowledges the support of the Sussex CADB.

COMMENT: The Mercer County Agriculture Development Board finds the proposal to be reasonable and believes that it provides greatest flexibility to county agriculture development boards. The CADB further noted that as a suburbanized area which is subject to great volatility in real estate prices as a response to market conditions, the CADB appreciates the alternatives presented which will allow the Board to continue farmland preservation efforts even in a changing market.

In addition, the Board requested a clarification to proposed N.J.A.C. 2:76-6.11(d)1ii. It is the Mercer CADB's understanding that that the Board may choose the best funding method on an application by application basis. However, the proposed rule does not specifically state whether the Board's selected formula must be used on all of the County's applications or whether a different formula can be selected for each application individually. Therefore, the Board recommends the following clarification:

N.J.A.C. 2:76-6.11(d)1ii. Notwithstanding (d)1 above, the board may choose, **for each application,** which of the two methods the Committee shall use to determine the percent cost share.

RESPONSE: The SADC acknowledges the Board's support for the proposed amendment. The Board expressed its concern that the proposed rule does not specifically state that the Committee's approval of a cost share grant is on an individual application. Although the proposed amendment does not specifically state that the cost share percentage is determined for each application, the Committee's approval of a cost share grant is on a specific application only. Throughout the Agriculture Retention and Development Act, N.J.S.A. 4:1C-11 et seq., c.32, P.L.1983 and this subchapter, reference to SADC actions and approvals are on an individual application. However, for clarification purposes, the Committee will incorporate the Board's recommended language in the adopted amendment.

COMMENT: The Middlesex County Agriculture Development Board expressed its support of the proposed amendment, as corrected in the October 18, 1993 New Jersey Register. The Middlesex CADB noted that the amendment states that the SADC cost share shall be based on either the landowner's formula index method or the landowner's asking price method (incremental sliding scale). The funding allocation method will be selected by the CADB after the landowner's offer has been submitted. It is appropriate that the CADB choose which method shall be used to determine the SADC's cost share. The choice of cost share methods confirms the policy that the farmland program seeks to preserve farms based on their quality and viability and not on the value of the land.

RESPONSE: The SADC acknowledges the support of the Middlesex County Agriculture Development Board.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

2:76-6.11 Final committee review

(a) (No change.)

(b) Upon receipt of applications which have received final approval by the board, the Committee shall determine the landowner's formula index by application of the formula contained in N.J.S.A. 4:1C-31b(1) as follows:

$$\frac{\text{nonagricultural development value} - \text{agricultural value} - \text{landowner's asking price}}{\text{nonagricultural development value} - \text{agricultural value}} = \text{formula index}$$

(c) (No change.)

(d) The Committee shall not authorize a grant for an amount greater than 80 percent of the Committee's certified fair market value of the development easement.

1. The percent Committee cost share shall be based upon the higher cost share percentage determined pursuant to the following two methods:

The landowner's formula index method:

Landowner's formula index	Percent committee cost share
Less than 0.10	60
0.10 up to less than 0.20	65
0.20 up to less than 0.30	70
0.30 up to less than 0.40	75
0.40 or greater	80

(or)

The landowner's asking price method:

Landowner's asking price	Percent committee cost share
From $0.00 to $1,000 =	80% above $ 0.00
From > $1,000 to $3,000 =	$ 800 + 70% above $ 1,000
From > $3,000 to $5,000 =	$2,200 + 60% above $ 3,000
From > $5,000 to $10,000 =	$3,400 + 50% above $ 5,000
From > $10,000 to $15,000 =	$5,900 + 25% above $10,000
From > $15,000 to $20,000 =	$7,150 + 10% above $15,000
From > $20,000 =	$7,650

i. If the landowner's asking price is greater than the certified fair market value, the Committee's cost share grant shall be based upon the Committee's certified fair market value.

ii. Notwithstanding (d)1 above, the board may choose*, **for each application,*** which of the two methods the Committee shall use to determine the percent cost share.

2.-3. (No change.)

(e)-(f) (No change.)

BANKING

(a)

Release of Bank Examination Reports to Independent Auditors

Proposed New Rule: N.J.A.C. 3:3-2.2 and 2.3

Proposed: November 1, 1993 at 25 N.J.R. 4819(a).

Adopted: December 13, 1993 by the Department of Banking, Jeff Connor, Commissioner.

Filed: December 22, 1993 as R.1994 d.49, **without change.**

Authority: N.J.S.A. 17:1-8.1 and 12 U.S.C. §1831m(a).

Effective Date: January 18, 1994.

Expiration Date: January 11, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

3:3-2.2 Definitions

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

"Independent auditor" means a certified public accountant or other person approved by the Commissioner who is retained by the depository institution pursuant to 12 U.S.C. §1831m(a) or N.J.S.A. 17:9A-253.

"Report of Examination" means documents obtained or prepared incident to an examination or audit of a financial institution pursuant to N.J.S.A. 17:9A-260, its holding institution or its subsidiary and any examination or audit report.

3:3-2.3 Release of Bank Examination Reports to independent auditors

(a) The Report of Examination shall be made available for inspection by an independent auditor retained by the depository institution in connection with the audit of the depository institution subject to the following conditions:

1. The independent auditor shall review the Report of Examination only on the premises of the institution and shall not make or retain any copies of such information; and

2. The independent auditor shall not disclose the confidential supervisory information for any purpose without the prior written approval of the New Jersey Commissioner of Banking except as necessary to provide advice to the institution.

COMMUNITY AFFAIRS

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code

Utility Load Management Device Installation Programs; Plan Review for Mausoleums; Department Fees

Adopted Amendments: N.J.A.C. 5:23-2.18A, 3.11 and 4.20

Proposed: October 4, 1993 at 25 N.J.R. 4546(b).
Adopted: December 10, 1993 by Stephanie R. Bush, Commissioner, Department of Community Affairs.
Filed: December 14, 1993 as R.1994 d.28, **without change.**

Authority: N.J.S.A. 52:27D-124.

Effective Date: January 18, 1994.
Expiration Date: February 3, 1998.

Summary of Public Comments and Agency Responses:

Comments were received from the following persons: H. Douglas Hansen, Construction Official, Village of Ridgefield Park; Richard M. Stokes, Manager, Government Affairs, Atlantic Electric; Kevin F. Connelly, Administrator, Residential Marketing Program, Jersey Central Power & Light Company; Jack J. Shea, Vice President/Mid-Atlantic, Demand Management Company; and Richard Fryling, Jr., General Solicitor, Public Service Electric and Gas Company.

COMMENT: Would it not be more accurate to provide, at N.J.A.C. 5:23-4.20(c)2iii(3), that the fee is charged for each load management device **inspected**?

RESPONSE: The language is correct as it is now written. N.J.A.C. 5:23-2.18A(j) provides that the payment that is to be made by the utility shall be in the amount of 30 percent of the permit fees due and owing. If, for example, 100 devices were installed, the fee, using the Department's fee schedule, would be $4,600. However, the utility only pays 30 percent of that fee, plus any administrative, training and certificate fees.

COMMENT: Fees charged to utilities will increase because municipalities will tend to adopt the Department's fee.

RESPONSE: Municipalities have typically charged lower fees than those of the Department and there is no reason to believe that they will continue to do so. The Department establishes the categories for which municipal fees may be charged, but does not set the amounts of those fees. The purpose of this amendment is to allow utilities, contractors and municipalities to realize savings by avoiding unnecessary paperwork.

COMMENT: The 30 percent inspection requirement is excessive and a lower number should be adopted.

RESPONSE: Any change in the 30 percent rule would have to be the subject of a new proposal. The Department does not favor such a change, however, because, while the overall failure rate for load management devices is low, several specific contractors have had a high failure rate. Inspecting 30 percent of the devices gives the inspector a better opportunity to have a representative sample of the contractor's work. Nevertheless, any evidence that the commenter may wish to submit to support a reduction in the percentage of devices inspected will be carefully reviewed.

Full text of the adoption follows:

5:23-2.18A Utility load management device installation programs

(a)-(e) (No change.)

(f) On the Monday following installations, the utility shall submit to each municipality a completed permit application for all installations completed in the municipality's jurisdiction during the preceding week.

1. A listing of all permits so delivered shall be filed by the utility with the Department.

2. All devices installed during that week, by a single contractor, shall be included on that application. The application shall include the Construction Permit Application (F100B) and an Electrical Subcode Technical Section (F120B).

3. Since the permit is not, typically, for work at a single location, the block number shall be entered as "UCC 2.18" and the lot as "A." The work site location shall be the name of the municipality and the owner in fee shall be the utility.

4. In addition to the Construction Permit Application, the utility or contractor shall supply the municipality a complete listing of locations where the devices, listed on this permit, were installed. This list shall include owner's name, owner's address, block and lot, date of installation, type of device(s) installed, and the contractor's name.

(g) If, for any reason, a permit application, or any part, is found to have been submitted in error, the utility or its contractors shall notify the municipality as soon as possible.

(h) When all required municipal and utility inspections have been approved, a single certificate of approval, for that permit, shall be issued to the utility.

(i)-(j) (No change.)

(k) The municipality shall inspect 30 percent of the installations performed and shall record the results of those inspections. The utility shall inspect at least 10 percent of the installations performed and shall record the results of those inspections and forward those results concurrently to the municipality and to the Department weekly.

(l)-(o) (No change.)

5:23-3.11 Enforcement activities reserved to the Department

(a) The Department of Community Affairs shall be the sole plan review agency for the following structures:

1.-5. (No change.)

6. Public mausoleums, vaults, crypts and other structures intended to hold or contain human remains; and

Recodify existing 6. as 7. (No change.)

(b)-(h) (No change.)

5:23-4.20 Departmental fees

(a)-(b) (No change.)

(c) Departmental (enforcing agency) fees shall be as follows:

1. (No change.)

2. The basic construction fee shall be the sum of the parts computed on the basis of the volume or cost of construction, the number of plumbing fixtures and pieces of equipment, the number of electrical fixtures and devices and the number of sprinklers, standpipes and detectors (smoke and heat) at the unit rates provided herein plus any special fees. The minimum fee for a basic construction permit covering any or all of building, plumbing, electrical, or fire protection work shall be $46.00.

i.-ii. (No change.)

iii. Electrical fixtures and devices: The fees shall be as follows:

(1)-(2) (No change.)

(3) For each motor or electrical device greater than 10 horsepower and less than or equal to 50 horsepower; for each service panel, service entrance, or sub-panel less than or equal to 200 amperes; for each transformers and generators greater than 10 kilowatts and less than or equal to 45 kilowatts; and for each utility load management device, the fee shall be $46.00.

(4)-(6) (No change.)

iv. (No change.)

3.-9. (No change.)

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

DIVISION OF FISH, GAME AND WILDLIFE

Marine Fisheries

Summer Flounder

Adopted Amendments: N.J.A.C. 7:25-18.1 and 18.14

Proposed: June 7, 1993 at 25 N.J.R. 2167(a).

Adopted: December 22, 1993 by Jeanne M. Fox, Acting Commissioner, Department of Environmental Protection and Energy.

Filed: December 22, 1993 as R.1994 d.44, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 23:2B-6 and 23:2B-14.

DEPE Docket Number 34-93-05.

Effective Date: January 18, 1994.

Expiration Date: February 15, 1996.

Summary of Public Comments and Agency Responses:

The New Jersey Department of Environmental Protection and Energy (Department) is adopting amendments to N.J.A.C. 7:25-18.1 and 18.14. The amendments were proposed on June 7, 1993 at 25 N.J.R. 2167(a). The comment period closed on July 7, 1993. Three individuals submitted original written comments, whle two separate form letters were received from 36 and 31 individuals, respectively.

The following is a list of persons submitting comments directly related to the proposal.

1. Robert Cope, Jr.
2. William C. Dickinson
3. Carl Benson
4. Form Letter #1

Allen Aliomar, Vincent Barrows, Deborah Byrne, (Name Unclear) Calo, Dolores Cardello, Fred Cassel, Wally Celimienny, Candace Cole, Charles DiDonna, Richard Evans, Jim Frauso, Amelia Fusiak, Jay Gosker, Earl Hanel, Raymond L., Nancy Lewis, Richard Mancud, J. McKeard, Thomas Musico, Cathleen Newman, Robert Odell, Mark Rubin, John Rumbasel, Janet Sondey, Jim Swenson, Walter Toth, Maureen Wilson, A. Wisely, Chris Cappiello, 7 letters with illegible signatures

5. Form Letter #2

Ronald Adams, Maria Bartauhak, Ira Berkowitz, Mitchell Brien, Kathleen Castro, Lester Dennis, Richard Flowers, Ruth Gant, Teresa Gattuso, Dale Grauer, Sean Hall, Mary Lee Horey, Robert Kalson, Thomas Kelly, Jim Lacey, M. Mauer, Davin Parow, Paul Reloquin, R. Chris Richard, Rafael Rodugis, Kathy Saudor, Lynn Skaurinski, Lawrence St. Tarcis, Bernard Vogel, John Wallzo, Carol Williams-Pride, Joseph Rosa, 4 letters with illegible signatures

The following is a summary of the comments received on the Department's proposal and the Department's responses to the comments.

General

1. COMMENT: The proposal for the commercial hook and line summer flounder fishery is fair, reasonable and enforceable. (1,2,5)

RESPONSE: The Department agrees with the commenters. The amendment was designed to permit those individuals, who have historically contributed to the commercial harvest and landing of summer flounder in New Jersey by hook and line, the opportunity to continue to engage in this activity. At the same time, the amendment is structured so hook and line fishermen who do not qualify for the commercial permit, will not be able to circumvent restrictions on minimum size limits, possession limits or the recreational fishing season. Only individuals being able to document their commercial landings with weigh out slips will be eligible for a permit for the commercial hook and line fishery.

2. COMMENT: Individuals who have sold summer flounder commercially in New Jersey that have been harvested by hook and line should be permitted to continue to do so because those previous landings contributed to New Jersey's total commercial landings which were utilized to develop the New Jersey commercial allocation. (1,2,4)

RESPONSE: The Department acknowledges receipt of this comment in support of the proposal. Commercial summer flounder landings taken by hook and line fishermen and sold to New Jersey dealers were recorded as New Jersey commercial landings. These landings, therefore, contributed to the allocation awarded to New Jersey's commercial fishery and those individuals who contributed to the landings should be permitted to participate in their historical fishery and have the opportunity to fish on the commercial allocation. To be eligible to participate in the commercial hook and line fishery, individuals must have landed and sold at least 1,000 pounds of summer flounder in New Jersey in each of two years during the period of 1985-1992, as any other commercial fishermen.

3. COMMENT: One commenter expressed concern as to the amount of time it has taken to implement the provision for a commercial hook and line fishery during which he or she has not been able to commercially harvest summer flounder. (3)

RESPONSE: The Department must follow the Administrative Procedures Act regarding the promulgation of rules or rule amendments. The process requires permitting adequate time for public review and comment. The Department is aware of the prime fishing season for the hook and line fishery and, as a result, only required a 30 day public comment period (as opposed to a 60 day period) to expedite the process. In addition, the Department has attempted to expedite the permitting process for this fishery by providing interested applicants with an application prior to adoption of the amendments. This provided the applicant an opportunity to complete the application and compile the necessary documentation to verify their previous participation in the fishery. Once received by the Department, the application was evaluated so eligible applicants could be issued a permit immediately upon adoption of the rule amendment.

4. COMMENT: Accurate and timely monthly reports are important for program success and the penalty established will result in higher compliance and better data in the future. (4)

RESPONSE: The Department concurs with the commenters' statement. The monthly reports required of individuals possessing a commercial New Jersey Summer Flounder Permit will provide the necessary data to verify commercial summer flounder landings reported by the National Marine Fisheries Service (NMFS). Since the commercial fishery operates on an annual allocation, it is essential for the success of the management program to receive accurate and timely reports of summer flounder landings. Suspension or revocation of an individual's New Jersey Summer Flounder Permit for failure to file the required monthly reports should provide incentive for permit holders to promptly submit the required monthly landing data. Timely submission of this data will enhance the Department's ability to effectively manage the resource.

5. COMMENT: The commenters indicated that the proposed change in how an overharvest of the first season quota would be handled was more equitable than the original rule. (4)

RESPONSE: The Department acknowledges receipt of this comment in support of the proposal. The first season (January-April) is primarily an offshore fishery with larger vessels while the second season (May-August) is an inshore fishery with smaller vessels. The third season (September-December) is a mix of both small and large vessels fishing both inshore and offshore as the fish migrate. Under the prior rule, should the first season's quota be exceeded, this overharvest was deducted from the second season. This penalized the smaller inshore fishing vessels which are incapable of fishing offshore during the winter. The potential significant impact which could result from a reduction to the second season quota is further exacerbated by the fact that it is the smallest of the three quotas. It represents less than half of the quota in either the first or third season. Since both large and small vessels fish during the third season, it is more equitable to deduct any overharvest occurring in the first two seasons from the third.

6. COMMENT: Commenters suggested that it was logical to limit an individual's New Jersey Summer Flounder Permit to the use of the fishing gear that was utilized to qualify for the permit, thereby protecting the investment of those who have traditionally participated in this economic venture. (4)

RESPONSE: The Department acknowledges receipt of this comment in support of the proposal. The purpose of this provision was to protect the historical investment that fishermen have made in the fishery and to allow their continued participation in this fishery.

7. COMMENT: Commenters suggested increasing the recreational possession limit from the existing six summer flounder to a limit of 10

to 15 summer flounder because the 14 inch minimum size limit meets the required reduction in summer flounder mortality. (5)

RESPONSE: The commenters' suggestion to increase the possession limit for the recreational fishery to 10 or 15 summer flounder goes beyond the scope of the amendment. The purpose of the Summer Flounder Management Plan (Plan) developed by the Atlantic States Marine Fisheries Commission (ASMFC) and the Mid-Atlantic Fishery Management Council (MAFMC) is to protect and manage summer flounder populations which are severely overfished. The Plan calls for a 47 percent reduction in summer flounder mortality. A 14 inch minimum size limit alone will not result in a 47 percent reduction. The six summer flounder possesion limit, the 14 inch minimum size limit and the limited fishing season (May 24-October 9) are necessary to comply with the 47 percent reduction in summer flounder fishing mortality for the recreational fishery. Increasing the possession limit of summer flounder to 10 to 15 fish would put New Jersey out of compliance with the Plan. Implementation of management measures not in compliance with the Plan would authorize the NMFS to prohibit landing of summer flounder from Federal waters in New Jersey. To increase the possession limit to 10 to 15 summer flounder and remain in compliance with the Plan would require that the minimum size limit be increased and/or the season drastically shortened. The Department, therefore, believes that retention of the six summer flounder possession limit is a management strategy which is most favorable to the interests of New Jersey fishermen.

The NMFS annually conducts stock assessments of fishery resources including summer flounder. The Northeast Regional Director of the NMFS is authorized to modify possession limits for summer flounder between 0 and 15 depending upon the abundance of summer flounder stocks. New Jersey regulations authorize the Commissioner of the Department, after consultation with the Marine Fisheries Council, to make the same adjustments to the State's summer flounder possession limits made by the Northeast Regional Director of the NMFS. Therefore, should the NMFS stock assessment indicate increased abundance of summer flounder, the Northeast Regional Director would have the authority to increase the possession limit. If this occurs, the Department would increase the possession limit accordingly.

Summary of Agency-Initiated Changes:

At N.J.A.C. 7:25-18.14(i)4i and 6i, the deadline for acceptance of applications for a summer flounder permit for hook and line applicants was changed from December 31, 1993 to May 31, 1994. It was necessary to incorporate this change due to the time that has elapsed between the proposal and adoption dates.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]):

7:25-18.1 Size and possession limits

(a)-(b) (No change.)

(c) A person angling with a hand line or with rod and line or spearfishing shall not possess any summer flounder or summer flounder parts beginning October 10 through May 23 nor shall any person angling with a hand line or with rod and line or spearfishing possess more than six summer flounder at any time during the period beginning May 24 through Octoer 9, except as provided in N.J.A.C. 7:25-18.14. The Commissioner, after consultation with the Marine Fisheries Council, may modify the possession limit of summer flounder during the open season (May 24 through October 9) by notice, to be consistent with the possession limit of summer flounder established by the Northeast Regional Director of the National Marine Fisheries Service. The possession limit shall be set from a range of 0 to 15. The Department shall provide notice of any change by filing and publishing in the New Jersey Register. All such notices shall be effective when the Department files notice with the Office of Administrative Law or as specified otherwise in the notice.

(d)-(q) (No change.)

7:25-18.14 Otter and beam trawls

(a)-(h) (No change.)

(i) Special provisions applicable to the commercial harvest of summer flounder are as follows:

1.-3. (No change.)

4. A vessel shall not land more than 100 pounds of summer flounder in New Jersey on any one trip, after March 5, 1993, unless said vessel is in possession of its valid New Jersey Summer Flounder Permit to participate in a directed fishery for summer flounder. The permit shall be issued in the name of the vessel and the owner and for the specific gear type used to qualify for the permit.

i. Applicants for a New Jersey Summer Flounder Permit shall complete an application provided by the Department and submit the application so it is received by the Department no later than June 30, 1993 for applicants applying to use otter trawls, pound nets, gill nets or scallop dredges and no later than *[December 31, 1993]* ***May 31, 1994*** for applicants applying to use hook and line. Applications for a New Jersey Summer Flounder Permit received after the above dates shall be denied.

ii. To be eligible for a New Jersey Summer Flounder Permit the vessel's owner shall meet the following criteria:

(1) The vessel shall have landed and sold at least 1,000 pounds of summer flounder in New Jersey in each of two years during the period of 1985-1992;

(2) The vessel shall have possessed a valid New Jersey otter trawl, pound net, or gill net license or a valid Federal summer flounder permit during each of the two years it qualified based upon the pounds of summer flounder landed and sold in (i)4ii(1) above. Vessels providing documentation regarding the amount of summer flounder landed for two years between January 1, 1985 to November 2, 1988 or vessels providing documentation of harvest by hook and line are exempt from this requirement; and

(3) (No change.)

iii. (No change.)

iv. A vessel possessing a New Jersey Summer Flounder Permit to commercially harvest summer flounder by angling or hook and line and when operating under the permit shall be subject to the following:

(1) Crew size shall be limited to no more than five persons, including the captain;

(2) The vessel shall not carry any passengers for hire. When carrying passengers for hire the New Jersey Summer Flounder Permit is not valid and the recreational size and possession limits and seasonal restrictions as specified in N.J.A.C. 7:25-18.1 apply.

v. A vessel that does not qualify for a New Jersey Summer Flounder Permit shall be permitted to land not more than 100 pounds of summer flounder on any trip, except that vessels taking summer flounder by angling or hook and line shall be subject to the possession limits established in N.J.A.C. 7:25-18.1.

5. The annual summer flounder harvest quota for New Jersey shall be determined by the Mid-Atlantic Fishery Management Council as implemented by the National Marine Fisheries Service. All landings of summer flounder in New Jersey shall be applied to the New Jersey annual summer flounder quota.

i.-v. (No change.)

vi. If the quota for either of the first two seasons is exceeded, the amount overharvested shall be deducted from the third season.

vii.-ix. (No change.)

6. Any person violating the provisions of this section shall be subject to the penalties prescribed in N.J.S.A. 23:2B-14 in addition to the following:

i. Failure to submit the application by June 30, 1993 for use of otter trawls, pound nets, gill nets or scallop dredges or by *[December 31, 1993]* ***May 31, 1994*** for use of hook and line or to attach the required documentation to the application shall result in the denial of the permit.

ii. (No change.)

iii. Failure to comply with the provisions of (i)5iii above, landing summer flounder after the season has been closed, or (i)5ix above, failure to submit accurate and timely monthly reorts, shall result in the suspension or revocation of the vessel's New Jersey Summer Flounder Permit according to the following schedule:

(1)-(3) (No change.)

iv. (No change.)

(j) (No change.)

HEALTH

(a)

DIVISION OF HEALTH FACILITIES EVALUATION AND LICENSING

Office of Emergency Medical Services
Mobile Intensive Care Programs

Adopted Amendment: N.J.A.C. 8:41-2.9, 4.1 and 10.1
Adopted New Rules: N.J.A.C. 8:41-10.5 through 10.13 and 8:41-11

Proposed: June 21, 1993 at 25 N.J.R. 2665(a).
Adopted: December 20, 1993 by Bruce Seigel, M.D., M.P.H., Commissioner of Health.
Filed: December 21, 1993 as R.1994 d.35, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).
Authority: N.J.S.A. 26:1A-15 and 26:2K-17.
Effective Date: January 18, 1994.
Expiration Date: June 21, 1998.

Summary of Public Comments and Agency Responses:

Comments were received from the following organizations and individuals:

St. Joseph's Hospital and Medical Center, Bergen/Passaic Mobile Intensive Care Consortium, Muhlenberg Regional Medical Center, The Mountainside Hospital, Robert Wood Johnson University Hospital, and Community Medical Center.

N.J.A.C. 8:41-4.1 Paramedic student selection

No comments were received.

N.J.A.C. 8:41-10 Standing orders

1. COMMENT: Several commenters stated that the standing order for intravenous therapy needed to be changed, as the standard which they are based upon was modified after the proposal. The commenters indicated that the wording should allow for some flexibility in the administration of fluids, based upon need and medical director determinations.

RESPONSE: The Department notes that the American Heart Association's standards for Advanced Cardiac Life Support were modified in several areas after the publication of these proposed rules. A review of those standards was made, based upon the data published in "The Journal of the American Medical Association," Volume 268, Number 16, pages 2171-2302. Additionally, the proposed changes were reviewed by a subcommittee of the MICU Advisory Council, which is comprised in part by the physician medical directors of MICU programs. Based upon these reviews, the Department has determined that certain changes were necessary to comply with the standard of care for the types of emergencies listed in these proposed rules. Additionally, the rule regarding the establishment of intravenous access (N.J.A.C. 8:41-10.4) is not specific to types of fluids. Accordingly, the rules have been changed at N.J.A.C. 8:41-10.1, 10.6, 10.7, 10.8, 10.9, 10.10, 10.12 and 10.13 to reflect the standard in N.J.A.C. 8:41-10.4.

2. COMMENT: Several commenters noted that the rules should carry some prohibition against administering any agent to which the patient has a known allergy.

RESPONSE: The commenters reflect a standard of practice which must be adhered to whenever performing a procedure under approved standing orders. Inclusion of this within these rules is appropriate, and will be added at N.J.A.C. 8:41-10.5.

3. COMMENT: One commenter requested further clarification as to what the term "Provide appropriate airway management" consisted of, and what actions were permissible.

RESPONSE: The term as used represents the standard of care which is expected from all prehospital advanced life support providers. This is inclusive of basic life support skills, which include the use of suction, oropharyngeal airways, bag-valve-mask devices in conjunction with oxygen, and other skills which are not considered advanced life support. This also includes the situations which require advanced life support intervention as defined by the standing orders for endotracheal intubation, found at N.J.A.C. 8:41-10.3.

N.J.A.C. 8:41-10.5 Applicability of standing orders

No comments were received.

N.J.A.C. 8:41-10.6 Sustained ventricular tachycardia

4. COMMENT: Two commenters stated that it was felt to be appropriate to administer some type of sedation prior to cardioversion of the patient, as it may be a traumatic experience.

RESPONSE: Cardioversion, the time synchronized delivery of an electrical shock, is only authorized under standing orders in the event the patient is unconscious, or is in a hemodynamically compromised state. In these instances, rapid delivery of the counter-shock is an essential component on the delivery of prehospital care. Additionally, some of the approved agents for sedation have side effects, which may not be indicated at the time of the emergency. If the patient is stable, the algorithm for stable ventricular tachycardia is to be followed (N.J.A.C. 8:41-10.6(a)). In the event that the prehospital advanced life support provider feels sedation is necessary, a consultation with the base station physician is required. Nothing in these rules prevents contact with the physician in the event the prehospital advanced life support provider deems it necessary. However, only these procedures are authorized before contacting the physician. No change is made to include sedation as part of the rule.

5. COMMENT: One commenter stated that it would be appropriate to decrease the blood pressure threshold found at N.J.A.C. 8:41-10.6(a) to 100 mmHg systolic, from 120 mmHg as was proposed, as many patients in the prehospital setting may have normal systolic blood pressures less than 120 mmHg.

RESPONSE: While the Department acknowledges that certain individuals may have a lower systolic blood pressure as their normal reading, it is difficult to determine whether the lower reading is secondary to a normal state, or related to the condition. In these cases, the patient (who is not clearly unstable) will benefit from the base station physician determination. No change is made.

6. COMMENT: Several commenters noted that the standards for the delivery of cardioversion had been changed (See Comment 1). The correct sequence of shocks should read 100 joules, 200 joules, 300 joules and 360 joules.

RESPONSE: As was discussed in Response 1, these changes meet the newer standards. The section will be changed accordingly.

N.J.A.C. 8:41-10.7 Bradycardia

7. COMMENT: Two commenters suggested that "if the patient is symptomatic and unstable" should be added to paragraph (a), as many individuals may have a bradycardic rhythm as a normal condition, and have no symptoms related to it.

RESPONSE: The intent of this rule was that intervention would only be performed in the event the condition was symptomatic. This addition makes that intent clear, and will be included with the adopted text.

N.J.A.C. 8:41-10.8 Pulmonary Edema/Congested Heart Failure; systolic blood pressure greater than or equal to 120 mmHg

8. COMMENT: One commenter stated that the blood pressure limit should be adjusted to 100 mmHg (see Comment 5).

RESPONSE: Again, due to the actions of some of the therapeutic agents, a physician determination of therapy is needed to assure that the proper treatment regimen is followed. Therefore, no change is made to change the limit listed in the rule.

9. COMMENT: Several commenters noted that the administration of nitroglycerin via the sublingual route may be either by tablet or spray, as is permitted by N.J.A.C. 8:41-8.

RESPONSE: The Department notes this is correct, and will change the rule to indicate that the dose of 0.4mg is to be administered sublingually, and not require the use of a tablet. This change will also be made at N.J.A.C. 8:41-10.9, Suspected myocardial infarction.

N.J.A.C. 8:41-10.9 Suspected myocardial infarction/chest pain: systolic blood pressure greater than or equal to 120 mmHg

10. COMMENT: One commenter stated that the blood pressure threshold was too high, as some individuals might have a normally lower systolic blood pressure. It was suggested that the limit be lowered to 100 mmHg.

RESPONSE: See Response 8. No change is made to this limit.

N.J.A.C. 8:41-10.10 Unstable paroxysmal supraventricular tachycardia: unconscious and hemodynamically unstable

11. COMMENT: Several commenters identified the fact that the standards for synchronized cardioversion in paroxysmal supraventricular tachycardia have been changed since the rule was proposed (see Comment 1). The new, recommended sequence listed in the standards is now 50 joules, 100 joules, 200 joules, 300 joules and 360 joules.

RESPONSE: The commenters are correct in this sequence. The rule is changed to reflect the current standard of care.

12. COMMENT: One commenter suggested that should the sequence of cardioversion fail to convert the rhythm, the protocol should be expanded to include the administration of adenosine.

RESPONSE: As this patient is unstable and/or hemodynamically compromised, the sequence of shocks is the immediate therapy indicated. Should this patient fail to convert to a rhythm which corrects the condition, the patient will benefit from the base station physician evaluating the situation and making a determination as to the proper course of therapy. Therefore, if the sequence listed is not successful, then base station contact is mandatory. At that time, the call is directed by the physician's best judgement, which could include adenosine. No addition to the protocol is made.

13. COMMENT: One commenter stated that if the EKG complex is wide, lidocaine may be indicated.

RESPONSE: See Response 12. No addition is made to the protocol.

14. COMMENT: One commenter suggested the use of some sedation should be considered prior to administering the countershocks.

RESPONSE: See Response 4. No change is made.

N.J.A.C. 8:41-10.11 Anaphylatic shock

15. COMMENT: One commenter suggested that the administration of 0.5mg of epinephrine intravenously should be considered at the end of the protocol, as epinephrine via the subcutaneous route may be less effective if the patient is severely compromised.

RESPONSE: While the rationale the commenter lists may be true, this type of patient may require additional therapy. Physician intervention is necessary in these instances to be certain that the proper treatment regimen is administered. Accordingly, no change is made to include this treatment without a physician order.

N.J.A.C. 8:41-10.12 Bronchospasm

No comments were received.

N.J.A.C. 8:41-10.13 Unconscious person

16. COMMENT: One commenter stated that the use of dextrose in this protocol should be withheld if the patient's blood sugar is determined to be normal (by use of a reagent strip).

RESPONSE: The first line of the rule states that "(t)he treatment of an unconscious person shall be directed by the suspected etiology of the event." This is interpreted to mean that if the cause is suspected to be a cerebrovascular event, and the blood sugar level is measured to be normal, it is permissible to withhold the dextrose. Similarly, a suspected opiate overdose may receive Naloxone, and no other agent, should the Naloxone be successful. The intent of this rule is to allow some flexibility in the order and method of treatment; however, once the condition is corrected no further treatment is authorized. Additionally, no treatment may be administered that is not allowed for in the rule.

N.J.A.C. 8:41-11.1 Category I; Skills Division

17. COMMENT: One commenter requested that N.J.A.C. 8:41-11.1(c)3 be changed to reduce the number of patients the student must suction via the endotracheal route from 10 to five.

RESPONSE: The Department notes that this proposed change would match the number of required endotracheal intubations listed at N.J.A.C. 8:41-11.1(d)2. The rule will be amended to reflect that five endotracheal suctionings shall be required.

18. COMMENT: One commenter requested that the rule at paragraph (c)5 be changed to permit students to administer medications other than those authorized by the Commissioner of Health for paramedics, as this would allow the student to practice intramuscular and subcutaneous injections with greater frequency. Additionally, it was stated that the preceptor nurse was standing next to the student, which insures adequate supervision.

RESPONSE: Paramedics, and therefore paramedic students, are permitted only to administer medications and perform those procedures which are authorized by the Commissioner (N.J.S.A. 26:2K-7). Additionally, there is no guarantee that the preceptor will be a registered nurse. A paramedic may serve in the role of preceptor or EMS educator. Accordingly, no change can be made to this item.

19. COMMENT: One commenter requested that the requirement at N.J.A.C. 8:41-11.1(c)6 (patients on ventilators) be made an optional experience. It was proposed as a required experience.

RESPONSE: The Department notes that this item is a necessary part of the clinical rotation, as portable ventilators are carried by some MICU programs. Additionally, many patients are at home on ventilators and may require emergency care. As such, this experience is an essential component of the clinical rotation. No change is made to make this optional.

20. COMMENT: One commenter stated that the last line of N.J.A.C. 8:41-11.1(d)1 is "obscured" and should be deleted.

RESPONSE: The Department notes that the text is both clear in its content and intent. No change will be made.

21. COMMENT: One commenter requested that the number of endotracheal intubations be raised from five to 10.

RESPONSE: The Department can forsee no benefit in the increase of the number of intubations required prior to endorsement to take the certification exam. The number of five intubations serves as a minimum standard; however, the student must also demonstrate clinical competency in the skill. In any skill area, the quantity is a threshold, but the standard is always deemed to be competency in the skill. Therefore, no change is made.

22. COMMENT: One commenter stated that rule appears to require that the majority of intubations occur in the prehospital field internship, which may require a student to exceed the minimum number of intubations listed at paragraph (d)2.

RESPONSE: The language of this section is such that it is recommended that the majority of the intubations be prehospital field experiences, not required. While this represents an educational goal, the final issue to be decided by the EMS educator is competence in intubations, not the location of the intubations. As a result, it would be possible for the EMS educator to endorse the student with five intubations performed in the operating room, provided that the student has demonstrated a clinical competence in the skill.

23. COMMENT: One commenter suggested that the wording of N.J.A.C. 8:41-11.1(e)1 should be modified to reflect that the experience is to be with 12 lead EKGs, and that it should be sufficient to obtain a copy of an EKG, not necessarily to perform the EKG reading.

RESPONSE: The Department agrees that this experience is intended to be 12-lead EKGs. The wording is changed to reflect this intent. However, part of the experience is related to being able to correctly perform 12-lead EKGs. Several MICU programs are currently obtaining 12-lead EKGs in the prehospital environment in order to expedite the diagnosis and treatment of evolving myocardial infarctions. Additionally, this experience is intended to familiarize the student with the proper placement of electrodes, and the consequences of misplacement. Therefore, no change is made to the requirement that the student perform the EKGs personally.

24. COMMENT: Several commenters stated that the requirement for a written evaluation at the completion of the category is unnecessarily vague. The commenters argue that the lack of a standardized test, with identified areas of knowledge to be measured and a standard passing level, makes the testing process arbitrary. It was suggested that an evaluation is proper, but that the mechanism should not be defined.

RESPONSE: The Department agrees that the lack of a standardized test makes a regulated written evaluation an unreliable, and possibly unfair, means of evaluation. Therefore, this section is changed to require an evaluation of competency in the skills and knowledge of the category, but does not require that the evaluation be in a written format.

N.J.A.C. 8:41-11.2 Category II; Specialty Care Division

25. COMMENT: One commenter requested that the number of assessments be excluded from the rule, and that pediatric patients be included in the requirement.

RESPONSE: The numbers listed at paragraph (a)1 serve as a threshold for completion; nothing should be construed to make these numbers a limit. Pediatric patient assessments are defined at subsection (c) of this section. No change is made to the wording of this paragraph.

26. COMMENT: One commenter stated that restricting medications to only those approved for use by paramedics may limit the experience of the student.

RESPONSE: See Comment and Response 18.

27. COMMENT: One commenter requested that the section at N.J.A.C. 8:41-11.2(a)1 be changed to read "Document proper medication administration by a New Jersey approved MICU route."

RESPONSE: With the exception of prohibiting the use of intravenous nitroglycerin, these rules only list approved agents, and not routes of administration. Therefore, no change can be made.

28. COMMENT: One commenter stated that rule regarding the medications cards (N.J.A.C. 8:41-11.2(a)5) was not clear regarding storage and enforcement.

RESPONSE: The purpose of the medication cards is to have the student research common medication which are often encountered in the performance of the duties of a paramedic. These medication cards are to be made on drugs which are not included in the list of approved medications found in N.J.A.C. 8:41-8. It is anticipated that the student would retain the cards as an aid to education, and that the EMS educator would verify and document the completion of this requirement in the student's record.

29. COMMENT: Two commenters stated that the observation of insertion and care of a pacemaker should be an optional experience, as this is not performed as a prehospital procedure.

RESPONSE: The Department agrees that although this experience is a benefit to the training of paramedic students, it is an optional experience. It will be moved to the optional skills list at paragraph (a)14 in this section.

30. COMMENT: Two commenters stated that the requirement to document the EKG reading on each monitored patient in the clinical area is cumbersome, in that the student may encounter 50 or more such patients.

RESPONSE: In evaluating this requirement, the Department has determined the purpose of this section is to help reinforce the pathophysiology of electro-physiological disorders. Many patients present in non-pathological rhythms. Accordingly, paragraph (a)7 is modified to require the student to document dysrhythmias and abnormal EKGs, with the appropriate interpretations.

31. COMMENT: One commenter stated that the participation in, and documentation of, in-hospital cardiac arrest resuscitation is counter-productive, as they run without regard for ACLS (advanced cardiac life support) standards by residents. The commenter also states that the requirement that the student participate in five prehospital resuscitations is cumbersome for units with low call volumes.

RESPONSE: The argument that the observation of in-hospital resuscitation of cardiac arrest cases, required at N.J.A.C. 8:41-11.2(a)8, is counter-productive lacks substance. Individuals may benefit from the observation of the application of ACLS standard by other health care professionals. Additionally, MICUs in New Jersey operate under direct physician supervision, so it is possible that a physician may deviate from an algorithm for good cause. The assertion that in-hospital cardiac arrests fail to meet standards is not documented. If a training program has identified that non-standard treatments are being utilized by any preceptor, that program has a duty to remove the person from the preceptor list. Additionally, it is hoped that the program would take the necessary steps to ensure the institutional QA processes were utilized. Also, there is no requirement that five resuscitations be prehospital resuscitations. This rule only requires that of a minimum of five resuscitations, one is an in-hospital resuscitation. No change is made to this section.

32. COMMENT: One commenter stated that the requirement for five defibrillations is excessive, that one defibrillation is the same as the next. The commenter stated that it may be difficult for the student to do five defibrillations in the prehospital experience.

RESPONSE: The Department notes that the skill of manual defibrillation requires demonstrated competence. The threshold of five defibrillations is adequate to determine repeated competence in the area. Defibrillations on manikins does not adequately mimic defibrillations on humans to ensure competence in the skill. Additionally, the requirement is that five defibrillations be performed during clinical training, not in the prehospital experience. Therefore, no change is made to this requirement.

33. COMMENT: One commenter stated that the nasogastric tube insertion is a required, not optional skill. The rule appears to permit the observation of the insertion, and not an actual insertion. The rule apparently is contradictory, in that it appears that the student may observe the procedure, but is compelled to utilize proper equipment.

RESPONSE: The Department agrees that the rule appears to be contradictory in the language used. However, the Department does not find that the actual insertion of the tube is required. Accordingly, the rule is amended to remove the reference to the utilization of equipment.

34. COMMENT: One commenter requested the deletion of the pneumatic anti-shock garment (PASG) as part of the clinical training objectives, as this is a basic life support skill, taught at the emergency medical technician (EMT) level.

RESPONSE: While the Department acknowledges that the PASG is part of the basic life support skill base of the EMT. However, the use of this device remains part of the National Standard Curriculum for Paramedics, promulgated by the United States Department of Health in accordance with 23 U.S.C. 401, et seq. As such, it must remain part of the official Statewide training program. No change is made to remove PASG from the objectives.

35. COMMENT: One commenter requested that the requirement at paragraph (a)13 be deleted, as not all of the conditions listed may be observed during the training period. The commenter also states that the didactic program covers these topics.

RESPONSE: The Department notes that the rule does not require the student to physically examine and observe these patients, although that would be beneficial. The requirement is that the EMS educator will ensure that the student is capable of identifying etiologies, clinical presentations and treatment modalities of these conditions. This is a skill that is essential to the performance of the paramedic. Additionally, while the didactic presents the material initially, reinforcement in the clinical setting is necessary. Therefore, no change is made to this section.

36. COMMENT: One commenter suggested that the use of an external pacemaker is a required skill for paramedics, and should be listed as such for students.

RESPONSE: The Department agrees that this skill is essential for paramedics, and is already required under N.J.A.C. 8:41-7. Accordingly, this skill is moved from the optional list to mandatory, in order to reflect the intent of these rules.

37. COMMENT: One commenter suggested that the pediatric case study be an optional experience.

RESPONSE: The Department notes that pediatric treatment of prehospital patients is often not emphasized enough. This requirement serves to require an in-depth review of the case history of a pediatric patient, and is needed to ensure proper education of the student. No change is made to this requirement.

38. COMMENT: One commenter stated that the medication cards listed under the psychiatry section is unnecessary (See Comment 28).

RESPONSE: See Response 28.

39. COMMENT: Several people commented on the requirement for a written evaluation (See Comment 24).

RESPONSE: See Response 24.

N.J.A.C. 8:41-11.3 Category III; Field Internship

40. COMMENT: One commenter requested that the language at paragraph (a)1 be changed to require radio reports on 10 patients, instead of the 20 patients as is proposed. The commenter also recommended that the language be changed to require documentation on each patient the student assesses, not only those which were treated.

RESPONSE: The Department feels that the current standard of 20 radio reports is adequate to allow the student to become proficient in relaying essential information to the base station physician. No change is made to this requirement. The Department finds that there is a benefit to the student documenting patients assessed, but not treated, as these patients may be triaged without physician consultation. The wording is changed to reflect this intent.

41. COMMENT: One commenter suggested that the requirement for submission of all required paperwork at the completion of the shift is impractical. It was suggested that the paperwork should be submitted upon request of the EMS educator.

RESPONSE: The Department agrees with the commenter and will change the wording of the paragraph to reflect that the documentation will be forwarded as designated by the EMS educator.

42. COMMENT: One commenter requested that the rules require a student to maintain a valid driver's license throughout the training period.

RESPONSE: The Department has evaluated this request, and has determined that this is not an essential component of the training program. If a sponsor feels that an individual does not need a driver's license, it may sponsor the student. These rules require the student to receive training in safe vehicle operation, but do not mandate that the

student operate the vehicle. The training may be a review of laws, policies and regulations which highlight the responsibilities of the operator of an emergency vehicle.

43. COMMENT: One commenter requested that the requirement that the clinical sponsor conduct a review of the safe driving habits and regulations of the New Jersey Division of Motor Vehicles is unfair in that driver training is not a function of the hospital.

RESPONSE: While there is no obligation that the hospital conduct behind the wheel operations with students, or permit students to operate vehicles, there is a need for the student to be aware of safe practices in the operation of emergency vehicles and the laws, regulations and policies that apply. Additionally, this session may occur as a classroom review of the material. To exclude this from the student's education would be inappropriate. No change is made to this section.

44. COMMENT: One commenter stated that the morgue experience listed in paragraph (b) is often difficult to obtain, as there are restrictions on who may be present at autopsies. Additionally, the autopsy may be performed at a facility that is not associated with the hospital (for example, the medical examiners facility).

RESPONSE: The Department acknowledges that the training program may not have any control in the ability of a student to witness an autopsy. This experience is needed for a review of anatomy, and for pathophysiological reviews. To make this section more appropriate, the Department has modified it to allow the experience to be obtained either by the student's presence at an autopsy, or by attending a program approved by the Department in lieu of an autopsy.

45. COMMENT: See Comments 24 and 39 regarding the written evaluation mechanism.

RESPONSE: See Responses 24 and 39.

46. COMMENT: One commenter suggested that the approved standing orders (subchapter 10 of these rules) are essential to the performance of the student, and should be required as a required knowledge base.

RESPONSE: The Department notes that this was included in the intent of the proposal as part of the performance of the student. It was included by reference at N.J.A.C. 8:41-11.3(a)6, in that students were expected to "(f)unction both independently and as a member of the team." Independent action can only occur when the student executes the approved standing orders in the presence of a preceptor, as outlined in subchapter 10. In order to classify the intent of this rule, this requirement is listed separately at N.J.A.C. 8:41-11.3(a)9.

Summary of Agency-Initiated Changes:

The address of the Office of Emergency Medical Services (OEMS) is changed at N.J.A.C. 8:41-2.9(b), as OEMS has moved to a new location.

A change is made to the standing orders for cardiac arrest found at N.J.A.C. 8:41-10.1, to reflect the standards applied to all of the adopted standing orders with regard to intravenous fluid administration. Also, the term "Electromechanical Dissociation (EMD)" is replaced with the recently adopted terminology "Pulseless Electrical Activity (PEA)". For further explanation, see Comment and Response 1.

A change is made to recodify N.J.A.C. 8:41-11.3. Paragraph (b) and foreword are intended to be separate from paragraph (a). No change is made to N.J.A.C. 8:41-11.3(a); however, N.J.A.C. 8:41-11.3(b) through (h) are recodified as N.J.A.C. 8:41-11.4, Program requirements. The sections are recodified as (a) through (g), respectively.

The statement at N.J.A.C. 8:41-11.3(b) (now N.J.A.C. 8:41-11.4(a)), "A minimum of 200 hours of field experience shall be documented prior to the successful completion of the didactic program . . ." was incorrect since, as required by the previous sentence, no one can begin clinical training until all the didactic material has been presented. The correct language is ". . . shall be documented after the successful completion . . .," and the text is changed to read correctly.

The spelling of nitroglycerin is corrected at N.J.A.C. 8:41-10.8 and 10.9.

The wording of N.J.A.C. 8:41-11.3(h) (now N.J.A.C. 8:41-11.4(g)) reflects the term "appendix." This is changed to reflect that the section is a subchapter.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

8:41-2.9 Waiver

(a) (No change.)

(b) A program seeking a waiver of part(s) of this chapter shall apply in writing to:

Office of Emergency Medical Services
New Jersey State Department of Health
[CN 364] ***CN 367***
Trenton, NJ 08625-*[0364]* ***0367***

SUBCHAPTER 4. TRAINING AND CERTIFICATION OF ADVANCED LIFE SUPPORT PERSONNEL

8:41-4.1 Paramedic student selection

(a) No person shall be enrolled as a paramedic student in any program, nor shall any person be eligible to be certified as a paramedic, unless that person:

1. Has reached his or her 18th birthday;

2. Has a high school diploma or its equivalent;

3. Is currently certified by the Commissioner as an Emergency Medical Technician-Ambulance (EMT-A), or Intermediate (EMT-I) in accordance with the standards established by the United States Department of Transportation pursuant to 23 U.S.C. 401 et seq. and incoporated herein by reference and maintains certification as at least an EMT-A throughout the training and until either certification as a paramedic or termination from the training program;

4. Maintains current certification in cardiopulmonary resuscitation to the level of professional rescuer, in accordance with the standards of the American Heart Association, and maintains the certification throughout the training and until either certification as a paramedic or termination from the training program;

5. Is physically capable of performing all required skills of a paramedic student; and

6. Has not been convicted of any crime, or an offense involving moral turpitude or drugs.

i. An applicant may apply for a waiver of this requirement from the Commissioner or designee, in accordance with N.J.A.C. 8:41-2.9.

8:41-10.1 Standing orders for cardiac arrest

(a) The following cardiac dysrhythmias and treatment protocols shall be considered standing orders in cardiac arrest:

1. For ventricular fibrillation or ventricular tachycardia (without pulse):

i.-iii. (No change.)

iv. Establish IV access *[with Dextrose 5 percent in water or normal saline; keep vein open.]* ***in accordance with the standards established at N.J.A.C. 8:41-10.4***;

v.-vi. (No change.)

2. For asystole:

i.-ii. (No change.)

iii. Establish IV access *[with Dextrose 5 percent in water or normal saline; keep vein open.]* ***in accordance with the standards established at N.J.A.C. 8:41-10.4***;

iv.-v. (No change.)

3. For *[Electromechanical Dissociation (EMD)]* ***Pulseless Electrical Activity (PEA)***:

i. (No change.)

ii. Establish IV access *[with Dextrose 5 percent in water or normal saline; keep vein open.]* ***in accordance with the standards established at N.J.A.C. 8:41-10.4***;

iii.-iv. (No change.)

(b) General guidelines are as follows:

1.-2. (No change.)

3. The program medical director shall determine *[if Dextrose five percent in water or normal saline shall be used]* ***The type of fluids to be used in each of the above cases***;

4.-5. (No change.)

8:41-10.5 Applicability of standing orders

(a) The standing orders established in N.J.A.C. 8:41-10.6 through 10.15, inclusive, may be adopted in their entirety by the medical director of an approved MICU program, after notification to the Office of Emergency Medical Services (OEMS). The standing orders shall not be altered or abbreviated or enhanced in any manner.

(b) The protocols established in N.J.A.C. 8:41-10.6 through 10.13 are initial treatment protocols which may be utilized by prehospital advanced life support providers operating on an approved MICU. These protocols apply only to patients over 12 years old, and may

be utilized prior to physician contact. In the event the implementation of these standing orders is delayed for any reason, the base station physician shall be contacted immediately.

(c) Any situation other than those specifically identified in these rules requires the prehospital advanced life support provider to contact the base station physician for medical command before providing any advanced life support treatment not authorized under N.J.A.C. 8:41-10.1 through 10.4, inclusive.

(d) These protocols shall not be interpreted as a requirement to administer advanced life support therapy prior to base station physician contact. The prehospital advanced life support providers may elect to contact the base station physician at any time during the provision of therapy, in accordance with this subchapter. Standing orders cease to be operative once base station physician contact is made.

(e) These standing orders shall not be considered to represent total patient management. Medical command shall be established after the protocols are utilized.

(f) The presence of an allergy to any medication in these rules shall be deemed to be a contraindication to the administration of that agent, and said agent shall not be administered under these protocols.

*[(f)]***(g)*** Each case utilizing these standing orders shall be reviewed in accordance with the standards established by N.J.A.C. 8:41-10.1(b)4.

8:41-10.6 Sustained ventricular tachycardia

(a) The following standing orders are authorized in the event a patient presents with a stable (systolic blood pressure greater than or equal to 120 mmHg) ventricular tachycardia:

1. Provide appropriate airway management;
2. Establish *[an intravenous line of five percent dextrose in water to keep vein open]* ***intravenous access in accordance with the standards set at N.J.A.C. 8:41-10.4***;
3. Perform patient assessment, including medical history and allergies;
4. Administer Lidocaine HCL at a dose of 1mg/kg IV push, if the patient is not allergic to it;
5. Continue to assess the patient and monitor the cardiac rhythm; and
6. Contact the base station physician.

(b) The following standing orders are authorized in the event a patient presents with an unstable (unconscious or hemodynamic compromise) ventricular tachycardia:

1. Provide appropriate airway management;
2. Establish *[an intravenous line of five percent dextrose in water to keep vein open]* ***intravenous access in accordance with the standards set at N.J.A.C. 8:41-10.4***;
3. Cardiovert the patient at *[50]* ***100*** joules. Check the pulse and monitor after the cardioversion;
4. If the rhythm fails to convert, cardiovert the patient at *[100]* ***200*** joules. Check the pulse and monitor after the cardioversion;
5. If the rhythm fails to convert, cardiovert the patient at *[200]* ***300*** joules. Check the pulse and monitor after the cardioversion;
6. If the rhythm fails to convert, cardiovert the patient at 360 joules. Check the pulse and monitor after the cardioversion;
7. If the rhythm is converted at any point, administer Lidocaine one mg/kg, if there is no history of allergy to the drug; and
8. Contact the base station physician for medical command.

8:41-10.7 Bradycardia

(a) The following standing orders are authorized in the case of bradycardia ***if the patient is symptomatic and/or hemodynamically unstable***:

1. Provide appropriate airway management;
2. Establish *[an intravenous line of five percent dextrose in water to keep vein open]* ***intravenous access in accordance with the standards set at N.J.A.C. 8:41-10.4***;
3. Administer Atropine Sulfate one mg IV *[if the patient is symptomatic and unstable]*; and
4. Contact the base station physician for medical command.

8:41-10.8 Pulmonary Edema/Congestive Heart Failure; systolic blood pressure greater than or equal to 120 mmHg

(a) The following standing orders are authorized in the case of pulmonary edema/congestive heart failure, with systolic blood presssure greater than, or equal to, 120 mmHg:

1. Provide appropriate airway management;
2. Establish *[an intravenous line of five percent dextrose in water to keep vein open]* ***intravenous access in accordance with the standards set at N.J.A.C. 8:41-10.4***;
3. Administer *[one nitroglycerine tablet]* ***nitroglycerin*** (0.4 mg) sublingually;
4. Administer Furosemide one mg/kg IV; and
5. Contact the base station physician for medical command.

8:41-10.9 Suspected myocardial infarction/chest pain: systolic blood pressure greater than or equal to 120 mmHg

(a) The following standing orders are authorized in the case of suspected myocardial infarction/chest pain, with systolic blood pressure greater than, or equal to, 120 mmHg:

1. Provide appropriate airway management;
2. Establish *[an intravenous line of five percent dextrose in water to keep vein open]* ***intravenous access in accordance with the standards set at N.J.A.C. 8:41-10.4***;
3. Administer *[one nitroglycerine tablet]* ***nitroglycerin*** (0.4 mg) sublingually; and
4. Contact the base station physician for medical command.

8:41-10.10 Unstable paroxysmal supraventricular tachycardia: unconscious and hemodynamically unstable

(a) The following standing orders are authorized in the case of unstable paroxysmal supraventricular tachycardia, with unconscious and hemodynamically unstable patient:

1. Provide appropriate airway management;
2. Establish *[an intravenous line of five percent dextrose in water to keep vein open]* ***intravenous access in accordance with the standards set at N.J.A.C. 8:41-10.4***;
3. Perform a synchronized cardioversion at *[75]* ***50*** joules. Check the patient's pulse and cardiac rhythm after the shock;

4. If the rhythm fails to convert perform a synchronized cardioversion at 100 joules. Check the patient's pulse and cardiac rhythm after the shock;

*[4.]***5.*** (No change in text.)

6. If the rhythm fails to convert perform a synchronized cardioversion at 300 joules. Check the patient's pulse and cardiac rhythm after the shock;

*[5.]***7.*** (No change in text.)
*[6.]***8.*** (No change in text.)

8:41-10.11 Anaphylactic shock

(a) This standing order shall apply when the patient exhibits signs of acute respiratory distress and/or hypotension (systolic blood pressure of less than 90 mmHg).

1. Provide appropriate airway management;
2. Establish an intravenous line of 0.9 percent normal saline and give a 300cc fluid bolus.
3. Administer Epinephrine 1:1000 sol. at a dose of 0.5 mg subcutaneously;
4. Administer 50 mg of Diphenhydramine HCL IV; and
5. Contact the base station physician for medical command.

8:41-10.12 Bronchospasm

(a) The standing order shall apply in the case of bronchospasm:

1. Provide appropriate airway management;
2. Administer albuterol 2.5 mg via nebulizer;

i. A program's medical director may elect to substitute metaproterenol or isoetharine for albuterol. This substitution shall be declared at the time these standing orders are authorized by the medical director and approved by the Department.

3. Establish *[an intravenous line of five percent dextrose in water to keep vein open]* ***intravenous access in accordance with the standards set at N.J.A.C. 8:41-10.4***; and
4. Contact the base station physician for medical command.

8:41-10.13 Unconscious person

(a) The treatment of an unconscious person shall be directed by the suspected etiology of the event. The following standing orders shall apply:

1. Provide appropriate airway management;
2. Draw a blood sample using a red-top tube;
3. Evaluate a blood glucose reagent strip, if available;
4. Establish *[an intravenous line of five percent dextrose in water to keep vein open]* ***intravenous access in accordance with the standards set at N.J.A.C. 8:41-10.4****;
5. Administer Naloxone 2 mg IV;
6. Administer Thiamine 100 mg IV;
7. Administer 25 gm of 50 percent dextrose in water IV; and
8. Contact the base station physician for medical command.

SUBCHAPTER 11. PARAMEDIC CLINICAL TRAINING OBJECTIVES

8:41-11.1 Category I; Skills Division

(a) Upon the successful completion of the laboratory, or other designated clinical area, the student will be able to:

1. Identify the proper equipment and materials for venipuncture and blood collection;
2. Identify the proper sites for venipuncture and prepare the patient for the procedure;
3. Perform a minimum of 20 venipunctures utilizing proper aseptic technique and the appropriate blood collection equipment;
4. In accordance with hospital policy, document the procedure performed on the patient's record; and
5. Document all procedures performed on the appropriate clinical sign off sheet.

(b) Upon successful completion of the intravenous therapy experience, the student will be able to:

1. Prepare the patient for the procedure;
2. Select the appropriate site for the procedure and prepare the necessary equipment to accomplish the orders. This includes selecting and preparing the solution, tubing and other associated equipment and calculate the correct rate of infusion;
3. Perform a minimum of 20 successful intravenous infusions. All infusions will be performed utilizing proper aseptic technique and be performed in less than five minutes. Completion of the hospital intravenous therapy certification program may be substituted for this requirement. Prior to completion of the clinical training program, the student will have successfully initiated a minimum of 50 intravenous infusions or cannulations and have demonstrated clinical competency in the skill;
4. In accordance with hospital policy, document all procedures on the patient record; and
5. Document all procedures performed, using the appropriate clinical sign off sheet.

(c) Upon successful completion of the respiratory therapy experience, or other designated clinical areas, the student will be able to:

1. Identify breath sounds on a minimum of 20 patients utilizing proper ausculatory technique. Prior to the conclusion of clinical training, the student will have identified and documented breath sounds on a minimum of 10 patients with rales, rhonchi and wheezing;
2. Demonstrate the correct application of the nasopharyngeal airway, oropharyngeal airway, esophageal obturator airway, esophageal gastric tube airway and the endotracheal tube. The student will perform these skills utilizing appropriate equipment, techniques and sites. All airway insertions will be recorded on the patient record, in accordance with hospital policy, and on the appropriate clinical sign off sheet. These skills will be evaluated by both observation and skill testing by the EMS Educator;
3. Demonstrate, utilizing appropriate equipment, the proper technique for suctioning orally, nasally, tracheally and endotracheally. Prior to the conclusion of clinical training, the student will have suctioned a minimum of *[10]* ***five**** patients with an endotracheal tube in place. All suctioning will be recorded on the patient record, in accordance with hospital policy, and on the appropriate clinical sign off sheet;
4. Identify the desired effect for medications administered by the respiratory therapist;
5. Prepare and administer a minimum of 10 nebulized medications. Only approved MICU medications are to be administered by the student. The student will perform this skill utilizing appropriate technique and dosage. All nebulized medication administrations will be recorded on the patient record, in accordance with hospital policy, and on the appropriate clinical sign off sheet;
6. Observe patients on ventilators. The student will be able to identify the various ventilator controls and settings. The student will be able to explain the rationale for the use of the ventilator; and
7. Optional Experiences: Observation of pulmonary function tests and bronchoscopy.

(d) Upon successful completion of the operating room, or other designated clinical area for intubation, the student will be able to:

1. Perform successful endotracheal intubation. The student will perform this skill utilizing appropriate equipment and techniques. This includes the appropriate preoxygenation, reoxygenation and verification of tube placement by inspection and auscultation. All endotracheal intubations will be recorded on the patient record, in accordance with hospital policy, and on the appropriate clinical sign off sheet; and
2. Prior to the conclusion of clinical training, the student will have successfully endotracheally intubated a minimum of five patients. It is recommended that the majority of these be performed in the prehospital environment.

(e) Upon successful completion of the E.K.G., or other designated clinical area, the student will be able to:

1. Perform a minimum of *[5]* ***five 12-lead**** electrocardiograms. A copy of each will be retained by the student for interpretation at a later date with the EMS educator; and
2. Identify the effects of medications and electrolyte imbalances on the interpreted electrocardiograms; and
3. As an optional experience, observe stress tests, echocardiograms, application of Holter monitors and cardiac catheterizations.

(f) Each clinical training program shall develop *[a written]* ***an**** evaluation mechanism covering all the objectives of the Category I clinical training objectives. Each student shall take and pass this examination prior to proceeding to Category II.

8:41-11.2 Category II; Specialty Care Division

(a) Upon successful completion of the clinical training experience in the Intensive Care Unit, Coronary Care Unit, Emergency Department and Mobile Intensive Care Unit, or designated clinical area, the student will be able to:

1. Document the performance of 20 complete patient histories/assessments using the appropriate clinical sign-off sheet. These histories/assessments will include a minimum of 5 neurological and 5 trauma assessments;
2. Demonstrate medication administration by the intramuscular, subcutaneous, sublingual, topical and intravenous routes. Use of appropriate medication administration equipment and the correct drug calculations are required. The student will document all medication administrations performed on the patient record, as per hospital policy and on the appropriate clinical sign off sheet. Only New Jersey approved MICU medications may be administered;
3. Identify the actions, indications, normal dosage range, side effects and contraindications of all medications administered;
4. Submit one case study from each patient care area. This will include the chief complaint, patient history, past medical history, current medications, clinical presentation, treatment modalities, response to care and patient outcome;
5. Prepare a minimum of 10 medication cards on medication other than those approved for use by paramedics, as defined by Subchapter 8 of these rules, and which were identified during the student's critical care experience. Each card will include the generic and trade names, actions, indications, contraindications, dosage range, routes of administration and adverse reactions;

6. *[Document the insertion of a pacemaker or the observation of the care of a patient with a pacemaker, on the appropriate clinical sign off sheet]* ***Demonstrate the proper application and use of an external cardiac pacemaker***;

7. Document a rhythm strip from every monitored patient ***displaying a dysrhythmia and/or abnormal EKG*** in each clinical care area. Each strip will be interpreted and the treatment modalities documented on the appropriate clinical sign off sheet;

8. Document the participation and/or observation of a minimum of one cardiac arrest on the appropriate clinical sign off sheet. Prior to the conclusion of the clinical training experience, the student will have participated in a minimum of five cardiac arrest resuscitations;

9. Demonstrate the appropriate technique and situations for the application of defibrillation and cardioversion. By the end of the clinical training experience, the student will have performed a minimum of five defibrillations and/or synchronized cardioversions;

10. Demonstrates appropriate treatment modalities for the patient in cardiac arrest utilizing the Advanced Cardiac Advanced Life Support guidelines of the American Heart Association;

11. Document the insertion, or observation of the insertion, of a nasogastric tube on the appropriate clinical sign off sheet. ***If the student has inserted the nasogastric tube,*** *[Document]* ***document*** the insertion on the patient record, in accordance with hospital policy. *[The student will utilize the appropriate equipment and techniques during the procedure.]* ***If the student has performed the insertion, the student shall document the proper use of equipment and technique during the procedure.***

12. Demonstrate the application of and discuss the principles of use of the PASG;

13. Identify etiologies, clinical presentation and treatment modalities of the following: Angina Pectoris, Acute Myocardial Infarction, Congestive Heart Failure, Ventricular and Aortic Aneurysm, Cardiogenic Shock, Myocardial Trauma, Acute Hypertensive Crisis, Diabetic Emergencies, Poisonings and Overdoses, Hypovolemic Shock, Acute Respiratory Failure, Chronic Obstructive Pulmonary Diseases (COPD), Asthma, Pneumonia, Head Injury and Coma, Cerebral Vascular Accident, Seizures, Burns, Infectious Diseases, Acute Abdomen, Renal Failure, Fractures, Septic Shock, Neurogenic Shock, Pulmonary Edema, Pulmonary Embolism and Anaphylaxis; and

14. As an optional experience, review and demonstrate, the use of *[external Pacemakers]* Doppler, *[and]* Infusion Pumps*, **and the observation of the insertion of internal pacemakers***.

(b) Upon successful completion of the clinical training experience in the obstetrical department, or other designated clinical area, the student will be able to:

1. Document the observation of a minimum of five vaginal deliveries on the appropriate clinical sign off sheet;

2. Identify the normal stages of labor;

3. Assist in the care of a newborn infant and the post partum mother. Document the experiences on the appropriate clinical sign off sheet;

4. Identify the etiologies, clinical presentations and treatment modalities for abnormal and common complications of deliveries; and

5. Optional Experience: Neonatal Intensive Care Unit.

(c) Upon successful completion of the pediatric clinical training objective, or the designated clinical area, the student will be able to:

1. Document a minimum of 5 pediatric patient histories/assessments on the appropriate clinical sign off sheet. These histories/assessments should be done at various stages of development;

2. Identify normal vital signs for each developmental milestone of childhood;

3. Identify the correct procedure for the administration of medications and intravenous fluids to the pediatric patient;

4. Identify the correct pediatric drug dosages for all approved MICU medications;

5. Submit one pediatric patient case study; and

6. As an optional experience, review/demonstrate the operation of a Pediatric Intensive Care Unit, Well Baby Clinic, and Apnea Monitor.

(d) Upon the successful completion of the clinical training objectives in the Psychiatry Department, or other designated clinical training area, the student will be able to:

1. Document the observation of any crisis interviews and/or interventions on the appropriate clinical sign off sheet. If this experience is unavailable to the student, the EMS Educator may orient the student to the procedures followed during these activities;

2. Submit one case study after observing a crisis interview or intervention. If the required experience is not available, the EMS Educator may substitute the requirement of having the student write a synopsis of the procedures followed during a crisis interview or intervention; and

3. Prepare a minimum of five medication cards on psychiatric drugs. These cards are to include the generic and trade name, actions, indications, contraindications, dosage range, routes of administration and adverse reactions.

(e) Each clinical training program shall develop *[a written]* ***an*** evaluation mechanism covering all the objectives of the Category II clinical training objectives. Each student shall take and pass this examination prior to proceeding to Category III.

8:41-11.3 Category III; Field Internship

(a) Upon the successful completion of the Field Internship and all other clinical training objectives, the student will be able to:

1. Perform adequate patient assessments, communicate via telemetry and correctly document on the approved patient run report on a minimum of 20 patients. Copies of all run reports are to be submitted to the EMS Educator for review. A treatment call record will be completed on every patient the student treats ***or assesses***. This record will be used by the EMS Educator to evaluate the types of patients the student has had experience with;

2. Submit a field observation report, completed by the field preceptor, *[at the conclusion of each shift]* ***according to the schedule established by the EMS educator***.

3. Demonstrate the ability to use and troubleshoot all equipment, including the vehicle, radio and adjunct equipment;

4. Demonstrate knowledge of safe driving habits in accordance with hospital policy and the regulations of the New Jersey Division of Motor Vehicles;

5. Demonstrate the ability to promote or demonstrate positive interpersonal skills with squads, hospital employees and the patients and their families;

6. Function both independently and as a member of the team;

7. Demonstrate the ability to assume responsibility in the field. This includes the ability to set priorities, organize patient care and maintain control of the emergency scene*[; and]*

8. Demonstrate clinical competency in the following skills: chest decompression, intraosseous infusion, external cardiac pacing, central venous access and AV shunt*[.]* ***; and***

9. Demonstrate knowledge and competence in the application of the approved standing order protocols as established by this subchapter.

8:41-11.4 Program requirements

*[(b)]***(a)*** The program shall document a minimum of 600 hours of clinical training for each student. No clinical training area shall be entered until all didactic material has been presented that is necessary for the student to meet the clinical training objectives of that area. A minimum of 200 hours of field experience shall be documented *[prior to]* ***after*** the completion of the didactic program. Hours of training in the following areas are mandated by the United State Department of Transportation National Standard Curriculum for Paramedics and the Department:

1. Emergency department	100 hours
2. Intensive/coronary care units	40 hours
3. Operating/recovery room	24 hours
4. Intravenous team, if available	8 hours
5. Pediatric unit	24 hours

6. Labor/ delivery/newborn nursery	24 hours
7. Psychiatric unit or crisis center	8 hours
8. Morgue	4 hours

i. The morgue experience may be obtained either by the student attending actual autopsies, or by attendance at a program provided by the Department.

*[(c)]****(b)*** (No change in text.)

*[(d)]****(c)*** (No change in text.)

*[(e)]****(d)*** Each clinical training program shall develop a final *[written]* evaluation mechanism covering all the objectives of these clinical training objectives. Each student shall take and pass this examination prior to receiving endorsement to take the State certification examination.

*[(f)]****(e)*** (No change in text.)

*[(g)]****(f)*** (No change in text.)

*[(h)]****(g)*** If a student fails to meet any of the minimum numbers for the performance of the required skills listed in this *[appendix]* ***subchapter***, the clinical EMS educator responsible for the student's training may make application to the Chief Administrator of OEMS for a waiver of that requirement in accordance with the provisions for waivers in N.J.A.C. 8:41-2.

(a)

DIVISION OF EPIDEMIOLOGY, ENVIRONMENTAL AND OCCUPATIONAL HEALTH SERVICES

Chapter IV of State Sanitary Code
Operation of Clinical Laboratories: Reporting by Laboratory Supervisors
Adopted Amendment: N.J.A.C. 8:44-2.11

Proposed: August 16, 1993 at 25 N.J.R. 3751(a).
Adopted: December 13, 1993 by the Public Health Council, William Frascella, Jr., O.D., Chairperson.
Filed: December 21, 1993 as R.1994 d.36, **with a substantive change** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:1A-7.

Effective Date: January 18, 1994.
Expiration Date: April 20, 1995.

Summary of Public Comments and Agency Responses:

Comments on the proposed amendment were submitted by Our Lady of Lourdes Medical Center.

COMMENT: The required reporting of telephone number, age, name and address of employer and other demographic information is not readily available in a hospital out-patient laboratory setting; this information should best be obtained directly from the ordering physician.

RESPONSE: By requiring the reporting of this information, the hospital laboratory can cite the amended rule, and, in turn, require that blood specimens be submitted by the physician with complete information. Reporting of complete information means that the New Jersey Department of Health will not have to make follow-up phone calls to the laboratory to obtain missing information.

COMMENT: How is reporting by out-of-State laboratories being handled?

RESPONSE: The New Jersey Department of Health does not have regulatory authority over out-of-State laboratories. Most of the major out-of-State laboratories report voluntarily. In addition, occupational lead registries maintained by other state health departments always forward reports of residents of New Jersey to the New Jersey Department of Health.

Summary of Agency-Initiated Changes:

In subsection (c), the words "... if patient is over 16 years old—" is inserted after "... age of the patient" and before "employer...." Employer information is needed on adults only, because the workplace is usually the source of exposure to the hazard. Children are not likely to be working and, therefore, are not likely to be exposed to lead at work. "Employer" is thus relevant only for reports of adults. This change does not alter the intent of the proposed amendment.

Summary of Hearing Officer Recommendations and Agency Responses:

A public hearing on the proposal was held on September 13, 1993. No comments were received at the hearing, and no recommendations were made by the hearing officer. The hearing record may be reviewed by contacting Susan Eates, Department of Health, CN 360, Trenton, NJ 08625.

Full text of the adoption follows (additions indicated in boldface with asterisks ***thus***):

8:44-2.11 Reporting by laboratory supervisors

(a) Laboratory supervisors shall:

1.-3. (No change in text.)

(b) Laboratory supervisors shall immediately report to the State Department of Health, results of laboratory examinations indicating levels of hazardous substances in blood and urine equal to or greater than the following:

1.-3. (No change.)

4. Cadmium

i. Blood cadmium levels equal to or greater than five ug/L of whole blood;

ii. Urine cadmium levels equal to or greater than three ug/gram creatinine.

(c) The reports required by (b) above shall contain the result of the laboratory examination, including units; the type of specimen tested; the sample number and date the sample was collected and analyzed; the name, address, telephone number, sex, and date of birth or age of the patient; ***if the patient is over 16 years old,*** the name, address, and telephone number of the employer; the patient occupation; the name, address, telephone number, and name of the medical facility of the requesting physician; and the name, address, telephone number of testing laboratory.

(b)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products
Adopted Amendments: N.J.A.C. 8:71

Proposed: November 1, 1993 at 25 N.J.R. 4844(a).
Adopted: December 14, 1993 by the Drug Utilization Review Council, Henry T. Kozek, Secretary.
Filed: December 21, 1993 as R.1994 d.37, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: January 18, 1994.
Expiration Date: November 24, 1998.

Summary of Public Comments and Agency Responses:

The Drug Utilization Review Council received the following comment pertaining to the products affected by this adoption.

COMMENT: In opposition to Alphapharm's triazolam tablets, the Upjohn Company reminds the Council that Food and Drug Administration (FDA) has standard requirements for the packaging and labeling of triazolam products. Those requirements include: patient package inserts, 10 tablet package, bulk bottles labeled for inpatient use, dosage guidelines for geriatric and debilitated patients.

RESPONSE: Since Alphapharm has not received FDA approval to market its triazolam product in the United States at this time, the Council deferred the review of this product.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the List of Interchangeable Drug Products was held on November 29, 1993. Mark A. Strollo, R.Ph., M.S., served as the hearing officer. One person attended the hearing. One comment was received as summarized above. The hearing officer recommended that the decisions be made based upon the available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified "not adopted," and referred the products identified as "pending" for further study.

The following products and their manufacturers were **adopted**:

Albuterol sulfate inh. soln 0.083%, 0.5%	Warrick
Albuterol syrup 2mg/5ml	Warrick
Albuterol tabs 2mg, 4mg	Novopharm
Amiloride HCl tabs 5mg	Par
Auralgan otic soln substitute	Hi-tech
Carbidopa/levodopa 10/100, 25/100, 25/250	Purepac
Chlorzoxazone tabs 250mg	Par
Clemastine fumarate tabs 1.34mg, 2.68mg	Geneva
Clindamycin phosphate topical soln 1%	Barre-Nat'l
Diltiazem HCl tabs 30mg, 60mg, 90mg, 120mg	Bristol
Dimetane DX liq substitute	HiTech
Erythromycin topical soln 2% pledgette	Syosset
Ethosuximide syrup 250mg/5ml	Copley
Glyburide tabs 1.25mg, 2.5mg, 5mg	Hoechst
Indomethacin caps 25mg, 50mg	Par
Methazolamide tabs 25mg, 50mg	Lederle
Metoprolol tartrate tabs 50mg, 100mg	Ciba-Geigy
Metoprolol tartrate tabs 50mg, 100mg	Mylan
Metronidazole tabs 250mg, 500mg	Par
Nadolol tabs 160mg	Bristol
Poly-Vi-Flor/Iron liq 0.5mg substitute	HiTech
Robitussin AC liq substitute	HiTech
Robitussin DAC liq substitute	Barre-Nat'l
Robitussin DAC liq substitute	HiTech
Rynatuss Ped. Susp. substitute	Ferndale
Rynatuss tabs substitute	Ferndale

The following product and its manufacturer was **not adopted**:

Levothyroxine tabs 88mcg, 112mcg, 137mcg	Rhone Poulenc

The following products and their manufacturers were **not adopted but still pending**:

Adenosine phosphate inj 25mg/ml	Steris
Allopurinol tabs 300mg	Geneva
Alprazolam tabs 0.25mg, 0.5mg, 1mg, 2mg	Mylan
Amiodarone tabs 200mg	Alphapharm
Ascorbic Acid inj 222mg/ml	Steris
Atenolol tabs 25mg	Danbury
B Complex 100 inj	Steris
B Complex with C & B-12 inj	Steris
Betamethasone sod. phosphate inj 4mg/ml	Steris
Bromocriptine mesylate tabs 2.5mg	Danbury
Brompheniramine maleate inj 10mg/ml	Steris
Bumetanide tabs 0.5mg, 1mg, 2mg	Zenith
Buspirone HCl tabs 5mg, 10mg	Danbury
Calcitonin-salmon inj 200iu/ml	Arcola
Cefaclor caps 250mg, 500mg	Zenith
Chlorpheniramine maleate inj 10mg/ml	Steris
Chlorpromazine HCl inj 25mg/ml	Steris
Chlorzoxazone tabs 250mg, 500mg	Ohm
Chorionic gonadotropin 5,000u, 10,000u	Steris
Cimetidine tabs 200mg, 300mg, 400mg, 800mg	Mylan
Clemastine fumarate syrup 0.67mg/5ml	Lemmon
Clotrimazole cream 1%	Taro
Desipramine tabs 10, 25, 50, 75, 100, 150mg	Danbury
Dexamethasone acetate susp. inj 8mg/ml	Steris
Dexamethasone NaPO4 inj 4mg/ml, 10mg/ml	Steris
Dexpanthenol inj 250mg/ml	Steris
Diazepam inj 5mg/ml	Steris
Dicyclomine HCl inj 10mg/ml	Steris
Dimenhydrinate inj 50mg/ml	Steris
Diphenhydramine HCl inj 10mg/ml, 50mg/ml	Steris
Dyphylline GG liquid	Hi-Tech
Edetate disodium inj 150mg/ml	Steris
Estradiol cypionate inj 5mg/ml	Steris
Estradiol valerate inj 20mg/ml, 40mg/ml	Steris
Fiorinal tabs substitute	Danbury
Fluphenazine HCl tabs 1mg, 2.5mg, 5mg, 10mg	Danbury
Isosorbide dinitrate tabs 20mg, 30mg, 40mg	Danbury
Methylprednisolone tabs 4mg, 16mg	Danbury
Metoclopramide HCl tabs 5mg	Danbury
Metoprolol tartrate tabs 50mg, 100mg	Purepac
Nadolol tabs 20mg, 40mg, 80mg, 120mg, 160mg	Zenith
Nadolol tabs 40mg, 80mg, 120mg	Danbury
Naproxen sodium tabs 275mg, 550mg	Mylan
Naproxen tabs 250mg, 375mg, 500mg	Mylan
Nortriptyline caps 10mg, 25mg, 50mg, 75mg	Mylan
Pindolol tabs 5mg, 10mg	Mutual
Primidone tabs 250mg	Linnett
Propoxyphene/APAP tabs 100/650	Danbury
Spironolactone/HCTZ tabs 50/50	Danbury
Terfenadine tabs 60mg	Geneva
Trazodone HCl tabs 150mg	Danbury
Triamterene/HCTZ caps 50/25	Zenith
Triazolam tabs 0.125mg, 0.25mg	Alphapharm

(a)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Adopted Amendments: N.J.A.C. 8:71

Proposed: January 4, 1993 at 25 N.J.R. 55(a).
Adopted: December 14, 1993 by the Drug Utilization Review Council, Henry T. Kozek, Secretary.
Filed: December 21, 1993 as R.1994 d.38, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: January 18, 1994.
Expiration Date: November 24, 1998.

Summary of Public Comments and Agency Responses:
No comments were received regarding the adopted products.

Summary of Hearing Officer's Recommendations and Agency Responses:
A public hearing on the proposed additions to the list of interchangeable drug products was held on February 1, 1993. Mark A. Strollo, R.Ph., M.S., served as hearing officer. Two persons attended the hearing. Two comments were offered, as summarized in a previous issue of the New Jersey Register (see 25 N.J.R. 1221(a)). The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," and referred the products identified as "pending" for further study.

The following products and their manufacturers were **adopted**:

Atenolol/chlorthalidone 50/25, 100/25	Mylan
Nadolol tabs 20mg, 40mg, 80mg	Mylan
Pindolol tabs 5mg, 10mg	Novopharm

The following products were **not adopted but are still pending**:

Aminophylline tabs 100mg, 200mg	West-ward
Cortisone acetate tabs 25mg	West-ward
Entex LA tabs substitute	Trinity
Histalet Forte substitute tabs	Trinity
Hydrocortisone tabs 20mg	West-ward
Ibuprofen tabs 400mg, 600mg, 800mg	Invamed
Metoclopramide oral solution 5mg/5ml	Silarex
Nadolol tabs 120mg	Mylan
Oxtriphylline/guaifenesin elixir 100/50 per 5ml	Barre-Nat'l
Phenytoin suspension 125mg/5ml	Barre-Nat'l
Piroxicam caps 10mg, 20mg	Purepac
Prednisone tabs 5mg, 10mg, 20mg	West-ward
Rynatuss tabs substitute	Trinity
Singlet LA caps substitute	Trinity
Triazolam tabs 0.125mg, 0.25mg	Mylan

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notices of adoption at 25 N.J.R. 1221(a), 1969(a), 2882(a), 4496(b) and 6061(b).

(a)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Adopted Amendments: N.J.A.C. 8:71

Proposed: September 7, 1993 at 25 N.J.R. 3906(a).
Adopted: December 14, 1993 by the Drug Utilization Review Council, Henry T. Kozek, Secretary.
Filed: November 21, 1993 as R.1994 d.39, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: January 18, 1994.
Expiration Date: November 24, 1998.

Summary of Public Comments and Agency Responses:
No comments were received regarding the adopted products.

Summary of Hearing Officer's Recommendations and Agency Responses:
A public hearing on the proposed additions to the List of Interchangeable Drug Products was held on September 27, 1993. Mark A. Strollo, R.Ph., M.S., served as the hearing officer. One person attended the hearing. The hearing officer recommended that the decisions be made based upon the available biodata. The Council adopted the products specified as "adopted" and referred the products identified as "pending" for further study.

The following products and their manufacturers were **adopted**:

Isosorbide dinitrate tabs 30mg	Par
Methazolamide tabs 25mg, 50mg	Copley

The following drugs were **not adopted but are still pending**:

Amiloride/HCTZ tabs 5/50	Danbury
Atenolol tabs 50mg, 100mg	Lemmon
Digoxin Tabs 0.125mg, 0.25mg, 0.5mg	ALRA
Dyphylline/Guaifenesin elixir	Silarx
Endal HD liquid substitute	Great Southern
Gemfibrozil tabs 600mg	Purepac
Metoprolol tartrate tabs 50mg, 100mg	Lemmon
Naproxen sodium tabs 275mg, 550mg	Copley
Naproxen tabs 250mg, 375mg, 550mg	Danbury
Phenazopyridine tabs 95mg	Manuf. Chemists
Triamterene/HCTZ tabs 37.5/25	Danbury

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notice of adoption at 25 N.J.R. 6060(c).

(b)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Adopted Amendments: N.J.A.C. 8:71

Proposed: July 6, 1993 at 25 N.J.R. 2802(b).
Adopted: December 14, 1993 by the Drug Utilization Review Council, Henry T. Kozek, Secretary.
Filed: December 21, 1993 as R.1994 d.40, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: January 18, 1994.
Expiration Date: November 24, 1998.

Summary of Public Comments and Agency Responses:
COMMENT: In opposition to Watson's levodopa/carbidopa tablets, Dupont Merck Pharmaceutical Company provided information concerning the narrowing therapeutic window for treating Parkinson's disease over time and the potential problem of dyskinesias with small changes of levodopa dosage.

In addition, Dupont submitted a clinician's viewpoint on generic substitution for patients taking the brand, Sinemet.

RESPONSE: In response to the comment and based upon the submitted biodata which reflected bioequivalency, the Council approved Watson's carbidopa/levodopa 10/100 and 25/100 strength tablets. The Council also rejected Watson's carbidopa/levodopa 25/250 strength tablets based on the statistical significance of the area under the curve and maximum concentration parameters in the biodata and the narrowing therapeutic window of Parkinsonism.

Summary of Hearing Officer's Recommendations and Agency Responses:
A public hearing on the proposed additions to the List of Interchangeable Drug Products was held on July 26, 1993. Mark A. Strollo, R.Ph., M.S., served as the hearing officer. One person attended the hearing. Two comments were offered, one comment as summarized above and the other summarized in a previous issue of the New Jersey Register (see 25 N.J.R. 4495(b)). The hearing officer recommended that the decisions be made based upon the available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified "not adopted," and referred the products identified as "pending" for further study.

The following products and their manufacturers were **adopted**:

Carbidopa/levodopa tabs 10/100 and 25/100	Watson

The following drugs were **not adopted**:

Carbidopa/levodopa tabs 25/250	Watson
Levothyroxine sodium tabs 25mcg, 50mcg	Rhone-Poulenc Rorer
Levothyroxine sodium tabs 75mcg, 100mcg	Rhone-Poulenc Rorer
Levothyroxine sodium tabs 125mcg, 150mcg	Rhone-Poulenc Rorer
Levothyroxine sodium tabs 175mcg, 200mcg	Rhone-Poulenc Rorer
Levothyroxine sodium tabs 300mcg	Rhone-Poulenc Rorer

The following drugs were **not adopted but are still pending**:

Alprazolam tabs 0.25mg, 0.5mg, 1mg	Geneva
Atenolol tabs 50mg, 100mg	Genpharm
Desipramine HCL tabs 25mg, 50mg, 75mg, 100mg	Eon
Imipramine HCL tabs 10mg, 25mg, 50mg	Eon
Naproxen tabs 500mg	Genpharm
Naproxen tabs 500mg	Mutual
Pergonal injection substitute 75IU, 150IU	Lederle
Tetracycline HCL caps 250mg	Eon

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notices of adoption at 25 N.J.R. 4495(b) and 6062(a).

HUMAN SERVICES

(c)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Home Care Services Manual

General Provisions, Home Care Community-Based Service Programs, Home Care Expansion Program (HCEP), HCFA Common Procedure Coding System (HCPCS) Appendix A, Fiscal Agent Billing Supplement

Adopted Amendments: N.J.A.C. 10:60-1.2, 2.2, 2.4, 2.5, 2.8, 2.9, 2.10, 2.12, 2.14, 2.16, 3.2, 3.3, 3.6, and 4.2

Adopted New Rules: N.J.A.C. 10:60-1.3 through 1.17

Adopted Repeal and New Rule: N.J.A.C. 10:60-1.1

Adopted Repeal: N.J.A.C. 10:60-2 and 6, Appendices A through H

Proposed: July 6, 1993 at 25 N.J.R. 2803(a).
Adopted: December 17, 1993 by William Waldman, Commissioner, Department of Human Services.
Filed: December 21, 1993 as R.1994 d.41, **with substantive and technical changes** not requiring additional notice and comment (see N.J.A.C. 1:30-4.3) and **with portions previously adopted at** 25 N.J.R. 5167(a).

Authority: N.J.S.A. 30:4D-6b(2), 7, 7a, b and c; 30:4D-12; 30:4E; 42 CFR 440.70, 170(f) and Section 1902(w) of the Social Security Act, 42 U.S.C. 1396a.

Effective Date: January 18, 1994.
Expiration Date: February 19, 1996.

Summary of Public Comments and Agency Responses:
No comments received.

Summary of Changes upon Adoption:

The Division of Medical Assistance and Health Services is adopting the remaining portion of N.J.A.C. 10:60 with minor, non-substantive changes added to N.J.A.C. 10:60-2.9(b) and 2.15(a), in order to make the wording in each rule consistent with the other, and to avoid the possibility of misinterpretation. There is no change in hours of private duty nursing or payment eligibility.

The Home Care Manual as proposed on July 6, 1993 remains essentially unchanged, with the exception at N.J.A.C. 10:60-2.9(b) and 2.15(a) of the clarification of the care required by a primary caregiver when private duty nursing services are provided during a 24-hour period consistent with the language used in the definition of "primary caregiver" proposed in N.J.A.C. 10:60-1.2. Primary caregivers shall be responsible for eight hours of care except under emergency circumstances when prior authorized.

The word "chapter" is being substituted for "Manual" in N.J.A.C. 10:60, as the term "chapter" is more appropriate, since the complete "manual" includes the Administration Chapter (N.J.A.C. 10:49), the service-specific chapter, such as Home Care Services, and the Fiscal Agent Billing Supplement.

Full text of the changes between proposal and adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal shown in brackets with asterisks *[thus]*):

CHAPTER 60
HOME CARE SERVICES *[MANUAL]*

SUBCHAPTER 1. GENERAL PROVISIONS

10:60-1.1 Purpose and scope

(a) The purpose of the home care services program, as delineated in this chapter, is to provide home care services to those individuals determined eligible.

(b) *[The Home Care Services Manual]* ***This chapter*** provides requirements for, and information about, the following programs:

1. Home health services;
2. Personal care assistant services;
3. Home and Community-Based Services Waiver programs, which include the following:

i. Home and Community-Based Services Waiver for the Elderly and Disabled, known as the Community Care Program for the Elderly and Disabled (CCPED);

ii. Home and Community-Based Services Waiver for Blind or Disabled Children and Adults (Model Waivers I, II, and III); and

iii. Home and Community-Based Services Waiver for Persons with AIDS and Children under five who are HIV Positive, known as AIDS Community Care Alternatives Program (ACCAP); and

4. Home Care Expansion Program (HCEP).

(c) Home health agencies, homemaker agencies, hospice agencies, and private duty nursing agencies are eligible to participate as Medicaid home care services providers. The services which each type of agency may provide and the qualifications required to participate as a Medicaid provider are listed in N.J.A.C. 10:60-1.2.

(d) General information about the home health services program and the personal care assistant services program are outlined in this subchapter. Specific program requirements are provided in N.J.A.C. 10:60-2.

(e) Requirements of the Home and Community-Based Services Waiver Programs and the Home Care Expansion Program are provided in N.J.A.C. 10:60-2 and 3, respectively.

(f) N.J.A.C. 10:60-4 HCFA Common Procedure Coding System—HCPCS, outlines the procedure codes used to submit a claim for services provided under the Personal Care Assistant services program, Home and Community-Based Services Waiver programs, and the Home Care Expansion Program.

10:60-1.2 Definitions

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

"Case Management" is defined as the process of on-going monitoring by the Medicaid District Office staff, of the delivery and quality of home care services, as well as the recipient/caregiver's satisfaction with the services. Such case management does not include the case management services provided under the waiver programs and HCEP (N.J.A.C. 10:60-2.3(b)1, 2.9(b)1 and 3.3(a)1). Case management ensures timely and appropriate provider responses to changes in care needs and assures delivery of coordinated services which promote maximum restoration and prevents unnecessary deterioration.

"Class C boarding home" means a boarding home which offers personal assistance as well as room and board, as defined by the Department of Community Affairs (see N.J.A.C. 5:27).

. . .

"Division" means the Division of Medical Assistance and Health Services.

. . .

"Homemaker-home health aide" means a person who:

1. Successfully completes a training program in personal care assistant services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide. A copy of the certificate issued by the New Jersey Department of Law and Public Safety, Board of Nursing or other documentation acceptable to the Division is retained in the agency's personnel file.
2. Successfully completes a minimum of 12 hours in-service education per year offered by the agency; and
3. Is supervised by a registered professional nurse employed by a Medicaid approved home health agency provider.

"Hospice agency" means a public agency or private organization (or subdivision of such organization) that is Medicare certified for hospice care in accordance with N.J.A.C. 10:53A, and has a valid provider agreement with the Division to provide hospice services.

"Hospice service" means a service package provided by a Medicaid approved hospice agency to recipients enrolled in the AIDS Community Care Alternatives Program (ACCAP) who are certified by an attending physician as terminally ill, with a life expectancy of up to six months. The service package supports a philosophy and method for caring for the terminally ill emphasizing supportive and palliative, rather than curative care, and includes services such as home care, bereavement counseling, and pain control. (For information regarding hospice services to regular Medicaid recipients under Title XIX, see Hospice Services Manual N.J.A.C. 10:53A).

"Levels of care" means two levels of home health care services, acute and chronic, provided by a certified, licensed home health agency, as needed, to Medicaid recipients, upon request of the attending physician.

1. "Acute home health care" means concentrated and/or complex professional and non-professional services on a continuing basis where there is anticipated change in condition and services required.
2. "Chronic home health care" means either a long or short-term uncomplicated, professional and non-professional services, where there is no anticipated change in condition and services required.

. . .

"Medicaid District Office" (MDO) means one of the Division's offices located throughout the State, which, for purposes of this manual, administers a home care quality assurance program through its case management staff via post-payment review.

. . .

"On-site monitoring" means a visit by Division staff to a homemaker agency, private duty nursing agency, or hospice agency to monitor compliance with this Manual.

. . .

"Personal care assistant" means a person who:

1. Successfully completed a training program in personal care services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide. A copy of the certificate or other documentation issued by the New Jersey Department of Law and Public Safety, Board of Nursing is retained in the agency's personnel file.

2. Successfully completes a minimum of 12 hours in-service education per year offered by the agency; and

3. Is supervised by a registered professional nurse employed by a Medicaid approved homemaker/personal care assistant provider agency.

...

"Physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

...

"Preadmission screening (PAS)" means that process by which all eligible Medicaid recipients, and individuals who may become Medicaid eligible within 180 days following admission to a Medicaid certified nursing facility, and who are seeking admission to a Medicaid certified nursing facility receive a preadmission screening by the Medicaid District Office professional staff to determine appropriate placement prior to admission to a nursing facility pursuant to N.J.S.A. 30:4D-17.10 (P.L. 1988, c.97).

"Primary caregiver" means an adult relative or significant other adult who accepts 24 hour responsibility for the health and welfare of the recipient. For the recipient to receive private duty nursing services in the Home and Community-Based Services Waiver Programs, the primary caregiver must reside with the recipient and provide a minimum of 8 hours of hands-on care to the recipient in any 24 hour period.

"Prior authorization" means the process of approval by the MDO for certain services prior to the provision of these services. Prior authorization also may be applied in other service areas in situations of an agency's continued non-compliance with program requirements. In accordance with N.J.A.C. 10:60-1.4, if a patient is enrolled in the Garden State Health Plan or a private HMO, authorization for reimbursement is required by the GSHP physician case manager or private HMO prior to rendering any service.

...

"Social worker" means a person who has a master's degree from a graduate school of social work accredited by the Council on Social Work Education, has one year of post-masters social work experience in a health care setting and is licensed to practice social work in the State of New Jersey.

...

10:60-1.3 Providers eligible to participate

(a) A home care agency or organization, as described in (a)1 through 4 below, is eligible to participate as a New Jersey Medicaid provider of specified home care services in N.J.A.C. 10:49-3.2:

1. A home health agency, as defined in N.J.A.C. 10:60-1.2;

i. Out-of-State home health agencies providing services to Medicaid recipients out of State, must meet the requirements of that state, including licensure, if applicable, and must meet all applicable Federal requirements.

2. A homemaker agency, as defined in N.J.A.C. 10:60-1.2;

i. A new provider shall be issued a Medicaid Provider Billing Number by the fiscal agent. Those Personal Care Assistance (PCA) providers already enrolled as providers of homemaker services in the CCPED program (see N.J.A.C. 10:60-2) shall use the same Medicaid Provider Billing Number issued for CCPED.

3. A private duty nursing agency, as defined in N.J.A.C. 10:60-1.2; and

4. A hospice agency, as defined in N.J.A.C. 10:60-1.2.

10:60-1.4 Covered home health services

(a) Home health care services covered by the New Jersey Medicaid program are limited to those services provided directly by a home health agency approved certified for Medicaid by the New Jersey Department of Health and approved in accordance to participate in the New Jersey Medicaid program or through arrangement by that agency for other services.

1. Medicaid reimbursement is available for these services when provided to Medicaid recipients in their place of residence, such as a private home, residential hotel, residential health care facility, rooming house and boarding home.

i. In residential health care facilities, homemaker-home health aide or personal care assistant services are excluded from Medicaid coverage.

ii. Home health services shall not be available to Medicaid recipients in a hospital or nursing facility.

(b) Covered home health care services are those services provided according to medical, nursing and other health care related needs, as documented in the individual plan of care, on the basis of medical necessity and on the goals to be achieved and/or maintained.

(c) Home health care services shall be directed toward rehabilitation and/or restoration of the recipient to the optimal level of physical and/or mental functioning, self-care and independence, or directed toward maintaining the present level of functioning and preventing further deterioration, or directed toward providing supportive care in declining health situations.

(d) The types of home health agency services covered include professional nursing by a public health nurse, registered professional nurse, or licensed practical nurse; homemaker-home health aide services; physical therapy; speech-language pathology services; occupational therapy; medical social services; nutritional services; certain medical supplies; and personal care assistant services, as defined in this section.

1. The home health agency shall provide comprehensive nursing services under the direction of a public health nurse supervisor/director as defined by the New Jersey State Department of Health. These services shall include, but not be limited to, the following:

i. Participating in the development of the plan of care with other health care team members, which includes discharge planning;

ii. Identifying the nursing needs of the recipient through an initial assessment and periodic reassessment;

iii. Planning for management of the plan of care particularly as related to the coordination of other needed health care services;

iv. Skilled observing and monitoring of the recipient's responses to care and treatment;

v. Teaching, supervising and consulting with the recipient and family and/or interested persons involved with his or her care in methods of meeting the nursing care needs in the home and community setting;

vi. Providing direct nursing care services and procedures including, but not limited to:

(1) Wound care/decubitus care and management;

(2) Enterostomal care and management;

(3) Parenteral medication administration; and

(4) Indwelling catheter care.

vii. Implementing restorative nursing care measures involving all body systems including, but not limited to:

(1) Maintaining good body alignment with proper positioning of bedfast/chairfast recipients;

(2) Supervising and/or assisting with range of motion exercises;

(3) Developing the recipient's independence in all activities of daily living by teaching self-care, including ambulation within the limits of the treatment plan; and

(4) Evaluating nutritional needs including hydration and skin integrity; observing for obesity and malnutrition;

viii. Teaching and assisting the recipient with practice in the use of prosthetic and orthotic devices and durable medical equipment as ordered;

ix. Providing the recipient and the family or interested persons support in dealing with the mental, emotional, behavioral, and social aspects of illness in the home;

x. Preparing nursing documentation including nursing assessment, nursing history, clinical nursing records and nursing progress notes; and

xi. Supervising and teaching other nursing service personnel.

2. Homemaker-home health aide services shall be performed by a New Jersey certified homemaker-home health aide, under the direction and supervision of a registered professional nurse. Services include personal care, health related tasks and household duties. In all areas of service, the homemaker-home health aide shall encourage the well members of the family, if any, to carry their share of responsibility for the care of the recipient in accordance with the written established professional plan of care.

i. Household duties shall be considered covered services only when combined with personal care and other health services provided by the home health agency. Household duties may include such services as the care of the recipient's room, personal laundry, shopping, meal planning and preparation. In contrast, personal care services may include assisting the recipient with grooming, bathing, toileting, eating, dressing, and ambulation. The determining factor for the provision of household duties shall be based upon the degree of functional disability of the recipient, as well as the need for physician prescribed personal care and other health services, and not solely the recipient's medical diagnosis.

ii. The registered professional nurse, in accordance with the physician's plan of care, shall prepare written instructions for the homemaker-home health aide to include the amount and kind of supervision needed of the homemaker-home health aide, the specific needs of the recipient and the resources of the recipient, the family, and other interested persons. Supervision of the homemaker-home health aide in the home shall be provided by the registered professional nurse or appropriate professional staff member at a minimum of one visit every two weeks when in conjunction with skilled nursing, physical or occupational therapy or speech-language pathology services. In all other situations, supervision shall be provided at the frequency of one visit every 30 days. Supervision may be provided up to one visit every two months, if written justification is provided in the agency's records.

iii. The registered professional nurse, and other professional staff members, shall make visits to the recipient's residence to observe, supervise and assist, when the homemaker-home health aide is present or when the aide is absent, to assess relationships between the home health aide and the family and recipient and determine whether goals are being met.

3. Special therapies include physical therapy, speech-language pathology services and occupational therapy. Special therapists/pathologists shall review the initial plan of care and any change in the plan of care with the attending physician and the professional nursing staff of the home health agency. The attending physician shall be given an evaluation of the progress of therapies provided as well as the recipient's reaction to treatment and any change in the recipient's condition. The attending physician shall approve of any changes in the plan of care and delivery of therapy services.

i. The attending physician shall prescribe in writing the specific methods to be used by the therapist and the frequency of therapy services. "Physical therapy as needed" or a similarly worded blanket order by the attending physician is not acceptable.

ii. Special therapists shall provide instruction to the home health agency staff, the recipient, the family and/or interested persons in follow-up supportive procedures to be carried out between the intermittent services of the therapists to produce the optimal and desired results.

(1) When the agency provides or arranges for physical therapy services, they shall be provided by a licensed physical therapist. The duties of the physical therapist shall include, but not be limited to, the following:

(A) Evaluating and identifying the recipient's physical therapy needs;

(B) Developing long and short-term goals to meet the individualized needs of the recipient and a treatment plan to meet these goals. Physical therapy orders shall be related to the active treatment program designed by the attending physician to assist the recipient to his or her maximum level of function which has been lost or reduced by reason of illness or injury;

(C) Observing and reporting to the attending physician the recipient's reaction to treatment, as well as, any changes in the recipient's condition;

(D) Documenting clinical progress notes reflecting restorative procedures needed by the recipient, care provided and the recipient's response to therapy along with the notification and approval received from the physician; and

(E) Physical therapy services which may include, but not be limited to, active and passive range of motion exercises, ambulation training, and training for the use of prosthetic and orthotic devices. Physical therapy does not include physical medicine procedures, administered directly by a physician or by a physical therapist which are purely palliative; for example, applications of heat in any form, massage, routine and/or group exercises, assistance in any activity or in the use of simple mechanical devices not requiring the special skill of a qualified physical therapist.

(2) When the agency provides or arranges for speech-language pathology services, the services shall be provided by a certified speech-language pathologist. The duties of a speech-language pathologist shall include, but not be limited to, the following:

(A) Evaluating, identifying, and correcting the individualized problems of the communication impaired recipient;

(B) Developing long and short-term goals and applying speech-language pathology service procedures to achieve identified goals;

(C) Coordinating activities with and providing assistance to a certified audiologist, when indicated;

(D) Observing and reporting to the attending physician the recipient's reaction to treatment, as well as, any changes in the recipient's condition; and

(E) Documenting clinical progress notes reflecting restorative procedures needed by the recipient, the care provided, and the recipient's response to therapy, along with the notification and approval received from the physician.

(3) The need for occupational therapy is not a qualifying criterion for initial entitlement to home health services benefits. However, if an individual has otherwise qualified for home health benefits, his or her eligibility for home health services may be continued solely because of his or her need for occupational therapy. Occupational therapy services shall include, but not be limited to, activities of daily living, use of adaptive equipment, and home-making task oriented therapeutic activities. When the agency provides or arranges for occupational therapy services, the services shall be provided by a registered occupational therapist. The duties of an occupational therapist shall include, but not be limited to, the following:

(A) Evaluating and identifying the recipient's occupational therapy needs;

(B) Developing long and short-term goals to meet the individualized needs of the recipient and a treatment plan to achieve these needs;

(C) Observing and reporting to the attending physician the recipient's reaction to treatment as well as any changes in the recipient's condition;

(D) Documenting clinical progress notes reflecting restorative procedures needed by the recipient, the care provided, and the recipient's response to therapy along with the notification and approval received from the physician; and

(E) Occupational therapy services shall include but not be limited to activities of daily living, use of adaptive equipment, and homemaking task oriented therapeutic activities.

4. When the agency provides or arranges for medical social services, the services shall be provided by a social worker, or by a social work assistant under the supervision of a social worker. These shall include, but not be limited to, the following:

i. Identifying the significant social and psychological factors related to the health problems of the recipient and reporting any changes to the home health agency;

ii. Participating in the development of the plan of care, including discharge planning, with other members of the home health agency;

iii. Counseling the recipient and family/interested persons in understanding and accepting the recipient's health care needs, especially the emotional implications of the illness;

iv. Coordinating the utilization of appropriate supportive community resources, including the provision of information and referral services; and

v. Preparing psychosocial histories and clinical notes.

5. When the agency provides or arranges for nutritional services, the services shall be provided by a registered dietitian or nutritionist. These services shall included, but are not limited to, the following:

i. Determining the priority of nutritional care needs and developing long and short-term goals to meet those needs;

ii. Evaluating the recipient's home situation, particularly the physical areas available for food storage and preparation;

iii. Evaluating the role of the family/interested persons in relation to the recipient's diet control requirements;

iv. Evaluating the recipient's nutritional needs as related to medical and socioeconomic status of the home and family resources;

v. Developing a dietary plan to meet the goals and implementing the plan of care;

vi. Instructing recipient, other home health agency personnel and family/interested persons in dietary and nutritional therapy; and

vii. Preparing clinical and dietary progress notes.

6. Medical supplies, other than drugs and biologicals, including, but not limited to, gauze, cotton bandages, surgical dressing, surgical gloves, ostomy supplies, and rubbing alcohol shall be normally supplied by the home health agency as needed to enable the agency to carry out the plan of care established by the attending physician and agency staff.

i. When a recipient requires more than one month of medical supplies, prior authorization for the supplies shall be requested and received from the appropriate Medicaid District Office. Requests for prior authorization of an unusual or an excessive amount of medical supplies provided by an approved medical supplier shall be accompanied by a personally signed, legible prescription from the attending physician. If a recipient is an enrollee of the Garden State Health Plan or a private HMO, prior authorization shall be obtained from the GSHP physician case manager or private HMO.

ii. When a recipient requires home parenteral therapy, the home health agency shall arrange the therapy prescribed with a medical supplier specialized to provide such services.

(1) Administration kits, supply kits and parenteral therapy pumps, not owned by the home health agency, shall be provided to the recipient and billed to the Medicaid program by the medical supplier.

(2) Provision of disposable parenteral therapy supplies which are required to properly administer prescribed therapy shall be the responsibility of the agency.

7. Personal care assistant services shall be as described in N.J.A.C. 10:60-1.7.

(e) Medical equipment is an item, article or apparatus which is used to serve a medical purpose, is not useful to a person in the absence of disease, illness or injury, and is capable of withstanding repeated use (durable). When durable medical equipment is essential in enabling the home health agency to carry out the plan of care for a recipient, a request for authorization for the equipment shall be made by an approved medical supplier. The request for authorization shall be submitted to the Medicaid District Office and shall include a personally signed, legible prescription from the attending physician, as well as a personally signed legible prescription from the GSHP physician case manager (if not the prescriber) and private HMO, if applicable. Durable medical equipment, either rented or owned by the home health agency, shall not be billed to the New Jersey Medicaid program (see Medical Supplier Services Manual, N.J.A.C. 10:59-1.5 and 1.7).

10:60-1.5 Certification of need for services

To qualify for payment of home health services by the New Jersey Medicaid program, the recipient's need for services shall be certified in writing to the home health agency by the attending physician. The nurse or therapist shall immediately record and sign verbal orders and obtain the physician's counter signature, in conformance with written agency policy.

10:60-1.6 Plan of care

(a) The plan of care shall be developed by the attending physician in cooperation with agency personnel. It shall include, but not be limited to, medical, nursing, and social care information. The plan shall be re-evaluated by the nursing staff at least every two months and revised as necessary, appropriate to the recipient's condition. The following shall be part of the plan of care:

1. The recipient's major and minor impairments and diagnoses;

2. A summary of case history, including medical, nursing, and social data;

3. The period covered by the plan;

4. The number and nature of service visits to be provided by the home health agency;

5. Additional health related services supplied by other providers;

6. A copy of physician's orders and their updates;

7. Medications, treatments and personnel involved;

8. Equipment and supplies required;

9. Goals, long and short-term;

10. Preventive, restorative, maintenance techniques to be provided, including the amount, frequency and duration;

11. The recipient's, family's, and interested persons involvement (for example, teaching); and

12. Discharge planning in all areas of care (coordinated with short and long-term goals);

i. As a significant part of the plan of care, a recipient's potential for improvement shall be periodically reviewed and appropriately revised. These revisions shall reflect changes in the medical, nursing, social and emotional needs of the recipient, with attention to the economic factors when considering alternative methods of meeting these needs.

ii. Discharge planning shall take the recipient's preferences into account when changing the intensity of care in his or her residence, arranging services with other community agencies, and transferring to or from home health providers. Discharge planning also provides for the transfer of appropriate information about the recipient by the referring home health agency to the new providers to ensure continuity of health care.

(b) The plan of care shall include the recipient's needs, make a nursing diagnosis, develop a nursing plan of care, provide nursing services and coordinate other therapeutic services to implement the approved medical and nursing plan of care.

(c) The plan of care shall include an assessment of the recipient's acceptance of his or her illness and recipient's receptivity to home health care services.

(d) The plan of care shall include a determination of the recipient's psycho-social needs in relation to the utilization of other community resources.

(e) The plan of care shall include a description of social services, when provided by the social worker, and be reviewed, with any referrals required to meet the needs of the recipient.

10:60-1.7 Clinical records

(a) Clinical records containing pertinent past and current information, recorded according to accepted professional standards, shall be maintained by the home health agency for each recipient receiving home health care services. The clinical record shall include, at a minimum, the following:

1. A plan of care as described in N.J.A.C. 10:60-1.6;

2. Appropriate identifying information;

3. The name, address and telephone number of recipient's physician;

4. Clinical notes by nurses, social workers, and special therapists, which shall be written, signed and dated on the day each service is provided;

5. Clinical notes to evaluate a recipient's response to service on a regular, periodic basis, which shall be written, signed and dated by each discipline providing services;

6. Summary reports of pertinent factors from the clinical notes of the nurses, social workers, and special therapists providing services, which shall be submitted to the attending physician at least every two months; and

7. When applicable, transfer of the recipient to alternative health care, which shall include transfer of appropriate information from the recipient's record.

10:60-1.8 Basis of payment for home health services

(a) For home health services, the New Jersey Medicaid program follows the Medicare principles of reimbursement, which are based upon the lowest of:

1. 100 percent of reasonable covered costs; or
2. The published cost limits; or
3. Covered charges.

(b) Interim reimbursement shall be made on the basis of 100 percent or less (if reasonable allowable cost is anticipated to be less) of covered charges.

(c) Retroactive settlement and final reimbursement shall be based on Medicare principles of reimbursement.

10:60-1.9 Out-of-State approved home health agencies

(a) Final reimbursement shall be made to out-of-State approved home health agencies on the basis of 80 percent of covered reasonable charges. There is no cost filing required. No retroactive settlement shall be made.

10:60-1.10 Personal care assistant services

(a) Personal care assistant services shall be provided by a certified licensed home health agency or by a proprietary or voluntary nonprofit accredited homemaker agency.

(b) Personal care assistant services are health related tasks performed by a qualified individual in a recipient's place of residence, under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care. These services are available from a home health agency or a homemaker agency.

1. The purpose of personal care is to accommodate long-term chronic or maintenance health care, as opposed to short-term skilled care required for some acute illnesses.

2. Personal care assistant services shall be reimbursable when provided to Medicaid recipients in their place of residence, including:

i. A private home;
ii. A rooming house;
iii. A boarding home (not Class C);
iv. A Division of Youth and Family Services' (DYFS) foster care home; or
v. A Division of Developmental Disabilities (DDD) foster care home.

(c) Personal care assistant services are described as follows:

1. Activities of daily living shall be performed by a personal care assistant, and include, but not be limited to:

i. Care of the teeth and mouth;
ii. Grooming such as, care of hair, including shampooing, shaving, and the ordinary care of nails;
iii. Bathing in bed, in the tub or shower;
iv. Using the toilet or bed pan;
v. Changing bed linens with the recipient in bed;
vi. Ambulation indoors and outdoors, when appropriate;
vii. Helping the recipient in moving from bed to chair or wheelchair, in and out of tub or shower;
viii. Eating and preparing meals, including special therapeutic diets for the recipient;
ix. Dressing;
x. Relearning household skills; and
xi. Accompanying the recipient to clinics, physician office visits, and/or other trips made for the purpose of obtaining medical diagnosis or treatment or to otherwise serve a therapeutic purpose.

2. Household duties that are essential to the recipient's health and comfort, performed by a personal care assistant shall include, but not be limited to:

i. Care of the recipient's room and areas used by the recipient, including sweeping, vacuuming, dusting;
ii. Care of kitchen, including maintaining general cleanliness of refrigerator, stove, sink and floor, dishwashing;
iii. Care of bathroom, including maintaining cleanliness of toilet, tub, shower and floor;
iv. Care of recipient's personal laundry and bed linen, which may include necessary ironing and mending;
v. Necessary bed-making and changing of bed linen;
vi. Re-arranging of furniture to enable the recipient to move about more easily in his or her room;
vii. Listing food and household supplies needed for the health and maintenance of the recipient;
viii. Shopping for above supplies, conveniently storing and arranging supplies, and doing other essential errands; and
ix. Planning, preparing and serving meals.

3. Health related activities, performed by a personal care assistant, shall be limited to:

i. Helping and monitoring recipient with prescribed exercises which the recipient and the personal care assistant have been taught by appropriate personnel;
ii. Rubbing the recipient's back if not contraindicated by physician;
iii. Assisting with medications that can be self-administered;
iv. Assisting the recipient with use of special equipment, such as walker, braces, crutches, wheelchair, after thorough demonstration by a registered professional nurse or physical therapist, with return demonstration until registered professional nurse or physical therapist is satisfied that recipient can use equipment safely;
v. Assisting the recipient with simple procedures as an extension of physical or occupational therapy, or speech-language pathology services; and
vi. Taking oral and rectal temperature, radial pulse and respiration.

(d) The duties of the registered professional nurse in the PCA program are as follows:

1. The registered professional nurse, in accordance with the physician's certification of need for care, shall perform an assessment and prepare a plan of care for the personal care assistant to implement. The assessment and plan of care shall be completed at the start of service. However, in no case shall the nursing assessment and plan of care be done more than 48 hours after the start of service. The plan of care shall include the tasks assigned to meet the specific needs of the recipient, hours of service needed, and shall take into consideration the recipient's strengths, the needs of the family and other interested persons. The plan of care shall be dated and signed by the personal care assistant and the registered nurse and shall include short-term and long-term nursing goals. The personal care assistant shall review the plan, in conjunction with the registered professional nurse.

2. Direct supervision of the personal care assistant shall be provided by a registered nurse at a minimum of one visit every 60 days, initiated within 48 hours of the start of service, at the recipient's place of residence during the personal care assistant's assigned time. The purpose of the supervision is to evaluate the personal care assistant's performance and to determine that the plan of care has been properly implemented. At this time, appropriate revisions to the plan of care shall be made. Additional supervisory visits shall be made as the situation warrants, such as a new PCA or in response to the physical or other needs of the recipient.

3. A personal care assistant nursing reassessment visit shall be provided at least once every six months, or more frequently if the recipient's condition warrants, to reevaluate the recipient's need for continued care.

(e) Recordkeeping for personal care assistant services shall include the following;

1. Clinical records and reports shall be maintained for each recipient, covering the medical, nursing, social and health related care in accordance with accepted professional standards. Such information must be readily available, as required, to representatives of the Division or its agents.

2. Clinical records shall contain, at a minimum,

i. An initial nursing assessment;
ii. A six-month nursing reassessment;
iii. A recipient-specific plan of care;

iv. Signed and dated progress notes describing the recipient's condition;

v. Documentation of the supervision provided to the personal care assistant every 60 days;

vi. A personal care assistant assignment sheet signed and dated weekly by the personal care assistant;

vii. Documentation that the recipient has been informed of rights to make decisions concerning his or her medical care; and

viii. Documentation of the formulation of an advance directive.

3. All clinical records shall be signed and dated by the registered professional nurse, in accordance with accepted professional standards, and shall include documentation described in 2 above.

10:60-1.11 Basis of payment for personal care assistant services

(a) Personal care assistant services shall be reimbursed on a per hour, fee-for-service basis for weekday, weekend and holiday services. Nursing assessment and reassessment visits under this program shall be reimbursed on a per visit, fee-for-service basis.

(b) Personal care assistant services reimbursement rates (see N.J.A.C. 10:60-4) are all inclusive maximum allowable rates. No direct or indirect cost over and above the established rates may be considered for reimbursement. At all times the provider shall reflect its standard charge on the Health Insurance Claim Form, 1500 N.J. (see Fiscal Agent Billing Supplement, Appendix A, incorporated herein by reference) even though the actual payment may be different. A provider shall not charge the New Jersey Medicaid program in excess of current charges to other payers.

(c) For reimbursement purposes only, a weekend means a Saturday or Sunday; a holiday means an observed agency holiday which is also recognized as a Federal or State holiday.

10:60-1.12 Limitations of home care services

(a) When the cost of home care services is equal to or in excess of the cost of institutional care over a protracted period (that is, six months or more), the MDO staff may opt to limit or deny the provision of home care services on a prospective basis.

(b) Private duty nursing shall be a covered service only for those recipients covered under EPSDT, Model Waiver III and the AIDS Community Care Alternatives Program (ACCAP). Under Model Waiver III and ACCAP, when payment for private duty nursing services is being provided by another source (that is, insurance), the Division will supplement payment up to a maximum of 16 hours per day, including services provided by the other sources, if medically necessary, and if cost of service provided by the Division is less than institutional care.

(c) Private duty nursing services shall be limited to a maximum of 16 hours in a 24 hour period, per person in Model Waiver III and ACCAP. There must be a live-in primary adult caregiver (as defined in N.J.A.C. 10:60-1.2) who accepts 24 hour per day responsibility for the health and welfare of the recipient unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60-2.9(b)2 for exceptions to 16 hour maximum in a 24 hour period.)

(d) For personal care assistant services, Medicaid reimbursement shall not be made for services provided to Medicaid recipients in the following settings:

1. A residential health care facility;
2. A Class C boarding home;
3. A hospital; or
4. A nursing facility.

(e) Personal care assistant services provided by a family member shall not be considered covered services and shall not be reimbursed by the New Jersey Medicaid program.

(f) Personal care assistant services shall be limited to a maximum of 25 hours per week. However, if there is a medical need for additional hours of service, this limit may be exceeded by the provider up to an additional 15 hours per week, under certain criteria, which follow:

1. If the caregiver is employed, ill, frail, or temporarily absent from the home for sickness or family emergency and therefore unable to participate adequately in providing medically necessary care to ensure the safety or well-being of the recipient;

2. If the recipient lives alone or has no caregiver, and is in need of medically necessary care to ensure his/her safety and well-being;

3. If the recipient is severely functionally limited and requires care to meet activities in daily living (ADL) needs, both in the morning and afternoon/evening; or

4. If the recipient's physical status/medical condition suddenly deteriorates, resulting in an increased need for personal care on a short-term basis until the stabilization of the health status.

(g) Additional hours under (f) above shall be medically indicated, as documented by the recipient's physician, and shall not be a companion service. The agency providing these increased services must notify the Medicaid District Office (MDO), either in writing or by telephone, about the recipient receiving more than 25 hours of PCA services. Failure to notify the MDO may result in non-payment of the hours in excess of the 25 hours. Services provided to these recipients will be included by the MDO in the post-payment quality assurance reviews.

(h) Homemaker services provided under CCPED/HCEP shall be provided by certified homemaker-home health aides. Homemaker services provided by a parent to a minor child or by a spouse to a spouse shall not be covered services and shall not be reimbursed by the Division.

10:60-1.13 Advance directives

(a) All home health, private duty nursing, hospice and personal care agencies participating in the New Jersey Medicaid program shall comply with the provisions of the Federal Patient Self Determination Act (P.L. 101-508) 1902(w) of the Social Security Act, 42 U.S.C. 1396a, and shall notify Medicaid recipients about their rights under P.L. 1991, c.201 to make decisions concerning their medical care and their right to formulate an advance directive.

1. Such agencies shall:

i. Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the home health or personal care agency about their rights under State law to make decisions concerning their medical care and the right to formulate an advance directive;

ii. Provide the New Jersey Department of Health (DOH) statement of New Jersey law, "Your Right to Make Health Care Decisions in New Jersey", to recipients upon initial visit for home health or personal care services, regarding their rights to make decisions concerning their medical care available from the DOH. Such rights include the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive for their health care;

iii. Provide written information to recipients, upon initial receipt of home health or personal care, concerning the agency's written policies on the implementation of such rights;

iv. Document in the recipient's medical record whether or not the recipient has executed an advance directive;

v. Not condition the provision of care, or otherwise discriminate against a recipient, based on whether or not the recipient has executed an advance directive;

vi. Ensure compliance with requirements of State law respecting advance directives; and

vii. Provide education for staff and the community on issues concerning advance directives.

2. The provisions in (a)1 above shall not prohibit the application of a State law which allows a home health or personal care agency to refuse to implement an advance directive based on conscientious objection. The New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201, does allow private religious affiliated health care institutions to develop institutional policies and practices defining circumstances in which they will decline to participate in the withholding or withdrawing of specific measures to sustain life. Such policies and practices shall be included in the health care agency's written policies.

10:60-1.14 Relationship of the home care provider with the Medicaid District Office (MDO)

(a) Preadmission screening (PAS) shall be required for all Medicaid-eligible individuals and other individuals applying for nursing facility (NF) services and/or the Home and Community-Based

Services Waiver programs. MDO professional staff shall conduct PAS assessments of individuals in hospitals and community settings to evaluate need for nursing facility services and to determine the appropriate setting for the delivery of services. Individuals in hospitals or community settings who are referred for nursing facility care and who have been determined by the MDO not to require nursing facility placement, or who select alternatives to nursing facility care, will be referred for home care services.

(b) A health services delivery plan (HSDP) shall be completed by the MDO staff at the conclusion of the PAS assessment and shall be a component of the referral package to the home care provider. The HSDP shall be forwarded to the authorized care setting and shall be attached to the recipient's medical record upon admission to a nursing facility or when the recipient receives services from home care agencies. The HSDP may be updated as required to reflect changes in the recipient's condition. The HSDP provides data base history which reflects current or potential health problems and required services. The discharge planning unit or social service department of the hospital shall provide home care agencies with HSDPs for individuals who have been assessed in a hospital setting. The MDOs shall provide HSDPs for individuals who have been assessed in a community setting during the PAS process.

(c) For the many individuals in the community setting referred for home care services outside the PAS process described in (a) above, an HSDP shall not be provided.

10:60-1.15 Standards of performance for post payment quality assurance review

(a) An initial visit to evaluate the need for home health services or personal care assistant services shall be made by the provider. Following the initial visit, the provider shall advise the MDO, using the HCFA 485 form or other MDO approved notification form, that services have begun for the recipient.

1. If the HCFA 485 is used, it shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services, however, shall be kept on file in the agency, with the prescription. Providers shall include the HSP (Medicaid) Case Number when completing the form. For the non-Medicare certified agency, the provider shall submit to the MDO an MDO approved notification form which shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services shall be kept on file in the agency.

2. The HCFA 485, or other appropriate MDO approved agency form, shall be submitted to the MDO upon initiation of services and once every 12 months thereafter on a continuing basis. Providers shall notify the MDO when services have been terminated.

3. On a random selection basis, MDO staff shall conduct post-payment quality assurance reviews. At the specific request of the MDO, the provider shall submit a plan of care and other documentation for those Medicaid recipients selected for a quality assurance review.

4. Upon completing the post-payment quality assurance review, the MDO shall forward a performance report to the provider, based on compliance with the standards described in this section.

(b) The professional staff from the MDO will use the standards listed below in (c) through (j) below to conduct a post-payment quality assurance review of home care services as provided to the Medicaid recipient.

(c) Skilled nursing services and visits shall be based on a comprehensive assessment performed by a registered professional nurse to identify care needs and required services and shall be provided as designated by the plan of care.

1. Home visits for nursing services shall be provided to the recipient as ordered by the physician and as designated by the standards of nursing practice.

2. The nurse shall make home visits as appropriate and as scheduled in the plan of care. Supervision of home health aide services is an integral component of these visits.

3. Services shall be within the scope of practice of personnel assigned.

4. Appropriate referrals for required services shall be instituted on a timely basis.

5. Nursing progress notes and plans of care shall reflect the significant changes in condition which require changes in the scope and timeliness of service delivery.

(d) Homemaker-home health aide and personal care assistant services shall be provided by the agency in accordance with the plan of care.

1. The aide shall arrive and leave each day as scheduled by the agency.

2. The same aide shall be assigned on a regular basis, with the intent of assuring continuity of care for the recipient, unless there are unsusual documented circumstances, such as a difficult recipient/caregiver relationship, difficult location, or personal reasons of aide or recipient/caregiver.

3. Services shall be within the scope of practice of personnel assigned.

4. Appropriate training and orientation shall be provide by licensed personnel to assure the delivery of required services.

5. The aide shall provide appropriate services as reflected in the plan of care and identified on the assignment sheet;

6. Home care services shall be provided to the recipient to maintain the recipient's health or to facilitate treatment of an illness or injury.

(e) Physical therapy, occupational therapy or speech-language pathology services shall be provided as an integral part of a comprehensive medical program. Such rehabilitative services shall be provided through home visits for the purpose of attaining maximum reduction of physical or mental disability and restoration of the individual to the best functional level.

1. The services shall be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the individual shall improve materially in a reasonable and generally predictable period of time, or that the services are necessary towards the establishment of a safe and effective maintenance program.

2. The complexity of rehabilitative services is such that it can only be performed safely and effectively by a therapist. The services shall be consistent with the nature and severity of the illness or injury. The amount and frequency of these services shall be reasonable and necessary, and the duration of each visit shall be a minimum of 30 minutes.

3. The services shall be specific and effective treatment for the recipient's condition and shall be provided in accordance with accepted standards of medical practice.

4. For physical therapy standards, see N.J.A.C. 10:60-1.4(d)3ii(l).

(f) Visits of social service professionals are necessary to resolve social or emotional problems that are, or may be, an impediment to the effective treatment of the individual's medical condition or rate of recovery.

1. Medical social services shall be provided as ordered by the physician and furnished by the social worker.

2. The plan of care shall indicate the appropriate action taken to obtain the available community resources to assist in resolving the recipient's problems or to provide counseling services which are reasonable and necessary to treat the underlying social or emotional problems which are impeding the recipient's recovery.

3. The services shall be responsive to the problem and the frequency of the services shall be for a prescribed length of time.

(g) Visits of a dietitian or nutritionist shall be provided as needed to resolve nutritional problems which are or may be an impediment to the effective treatment of the recipient's medical condition or rate of recovery.

1. Nutritional services shall be provided as ordered by the physician and furnished by a dietitian or nutritionist in accordance with accepted standards of professional practice.

2. The plan of care shall indicate the nutritional care needs and the goals to meet those needs.

3. Services shall be provided to the recipient and/or the family/interested others involved with the recipient's nutritional care.

4. The services shall be specific and for a prescribed period of time.

5. The progress notes and care plan shall reflect significant changes or problems which require changes in the scope and timeliness of service delivery visits.

(h) The services shall be provided to the satisfaction of the recipient/caregiver.

1. There shall be documented evidence that the recipient/caregiver has participated in the development of the plan of care.

2. Identified problems shall be resolved between the agency and the recipient/caregiver, when possible.

3. The agency shall make appropriate referrals for unmet recipient needs.

4. The recipient/caregiver shall be promptly informed of changes in aides and/or schedules.

5. Recipients/caregivers shall be aware of the agency name, telephone number, and contact person in the event of a problem.

(i) The home health agency shall be aware of the recipient's need for, and shall make the appropriate arrangements for, securing medical equipment, appliances and supplies, as follows:

1. The agency shall assist the recipient in obtaining equipment, appliances, and supplies when needed under Medicare and/or Medicaid guidelines;

2. The agency shall monitor equipment, appliances and supplies to assure that all items are serviceable and used safely and effectively; and

3. The agency shall be responsible for contacting the provider for problems relating to the utilization of equipment, appliances and supplies.

(j) Recordkeeping shall be timely, accurate, complete and legible, in accordance with this chapter, and as follows:

1. There shall be a current aide assignment sheet for each recipient, available either in the home or at the agency, dated and signed by the nurse. The assignment shall be based on a nursing assessment of the recipient's needs and shall list the aide's duties as required in the plan or care;

2. The agency shall document significant changes in health and/or social status, including recent hospitalization, in the progress notes and make appropriate changes in the plan of care as needed;

3. Initial evaluations and progress notes shall be provided to the MDO upon request for all nursing services; and

4. Initial evaluations, progress notes and goals shall be provided to the MDO upon request for physical, occupational and speech-language therapies and social services.

10:60-1.16 On-site monitoring visits

(a) For a homemaker agency and a private duty nursing agency, on-site monitoring visits shall be made periodically by Division staff to the agency to review compliance with personnel, recordkeeping and service delivery requirements (Home Care Agency Review Form, FD-342). The results of such monitoring visits shall be reported to the agency, by the Medicaid District Office, and when indicated, a plan of correction shall be required. Continued non-compliance with requirement shall result in such sanctions as curtailment of accepting new recipients for services, suspension or rescission of the agency's provider agreement.

(b) For a hospice agency, on-site monitoring visits shall be made periodically by Division staff to the agency to review compliance with personnel, recordkeeping and service delivery requirements (Hospice Agency Review Summary Form, FD-351). The results of such monitoring visits shall be reported to the agency with a copy to the Medicaid District Office, and when indicated, a plan of correction shall be required. Continued non-compliance with requirements shall result in such sanctions as curtailment of accepting new recipients for services, suspension or rescission of the agency's provider contract.

10:60-1.17 Provisions for fair hearings

Providers and recipients can request fair hearings as set forth in the Administration chapter at N.J.A.C. 10:49-9.10.

SUBCHAPTER 2. HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

10:60-2.1 (No change in text.)

10:60-2.2 Eligibility requirements for CCPED

(a) Financial eligibility for CCPED is determined by the county welfare agency/board of social services which serves the county where an individual resides. The standards used for income eligibility are set forth in N.J.A.C. 10:71-5.6(c)4, Table B, entitled "Variations in Living Arrangements." Both the Supplemental Security Income (SSI) community standard and the Medicaid institutional standard appear in this table. The actual amounts, recomputed periodically based upon the cost-of-living increase, are subject to change each time a cost-of-living increase occurs.

1. Recipients financially eligible for Medicaid services under the community eligibility standards are not covered under CCPED. CCPED also does not serve recipients who are eligible under the New Jersey Care ... Special Medicaid Programs, including the Medically Needy segment of that program, or enrolled in the Garden State Health Plan or private HMO serving the Medicaid eligible population.

(b)-(e) (No change.)

10:60-2.3 (No change in text.)

10:60-2.4 Procedures used as financial controls for CCPED

(a) Total program costs shall be restricted by limits placed on the number of community care slots assigned each county and on per recipient costs. The Division may elect to exclude individuals for whom there is an expectation that costs to Medicaid for waiver services may exceed the cost of nursing facility care.

(b)-(c) (No change.)

10:60-2.5 Basis for home health agency reimbursement and cost reporting (CCPED)

(a) A home health agency participating in the CCPED program shall be reimbursed by the New Jersey Medicaid program on a fee-for-service basis for home health services provided. Fees shall be based on the lower of audited cost report data which is inflated to the current year, Medicare cost limits or agency charges. Agencies shall be precluded from receiving additional reimbursement for the cost of the community care services above the fee established by the Medicaid program. This applies to both freestanding and hospital-based home health agencies.

1. (No change.)

(b)-(c) (No change.)

Recodify existing N.J.A.C. 10:60-3.6 and 3.7 as 2.6 and 2.7 (No change in text.)

10:60-2.8 Eligibility requirements for Model Waivers

(a) Program eligibility criteria for Model Waivers are as follows:

1. (No change.)

2. For Model Waiver I and II, a recipient's total income shall exceed the SSI community standard, up to the institutional cap or the recipient must be ineligible in the community because of SSI deeming rules. Model Waiver III, however, shall serve the recipient who is eligible for Medicaid in the community, including New Jersey Care ... Special Medicaid Programs, as well as the recipient whose total income exceeds the community standard, up to the institutional cap. Model Waiver III shall not serve a Medicaid recipient eligible under the Medically Needy segment of the New Jersey Care ... Special Medicaid Programs nor enrolled in the Garden State Health Plan or a private Health Maintenance Organization (HMO) serving the Medicaid eligible population.

3. (No change.)

Recodify existing 5.-7. as 4.-6. (No change in text.)

(b)-(c) (No change.)

10:60-2.9 Services included under the Model Waiver programs

(a) Except for nursing facility services, all approved services under the New Jersey Medicaid program as described in N.J.A.C. 10:49, Administration, are available under the Model Waiver programs from approved Medicaid providers.

(b) Additional waivered services are as follows:

1. (No change.)

2. Private-duty nursing: A waivered service provided under Model Waiver III only and not under Model Waiver I or II. Private-duty nursing shall be provided in the community only, not in an inpatient hospital setting. The recipient shall have a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the recipient. A maximum of 16 hours of private-duty nursing *[includes payment by any source]* may be provided in any 24-hour period. *[Provision of the additional]* ***A minimum of*** eight hours of ***hands on*** care shall be *[the responsibility of]* ***provided by*** the primary caregiver. There is no 24 hour coverage except for a limited period of time under the following emergency circumstances and when prior authorized by the Office of Home Care Programs:

i. For brief post-hospital periods while the caregiver(s) adjust(s) to the new responsibilities of caring for the discharged recipient; or

ii. In emergency situations such as the illness of the caregiver when private duty nursing is currently being provided. In these situations, more than 16 hours of private duty nursing services may be provided for a limited period until other arrangements are made for the safety and care of the recipient.

(c) (No change.)

*[(c)]***(d)*** The need for private duty nursing services is established initially by the RSN upon completion of the PAS-1 and HSDP (N.J.A.C. 10:60-1.11(a)). The number of hours of private duty nursing included in the service plan is based upon the recipient's medical need and the cost of service. The total cost of all services provided through Model Waiver III must be less than the cost of care in an appropriate institution. The need for private duty nursing services and the hours of private duty nursing services may increase or decrease as the recipient's medical status changes, and correspondingly, as the service cost cap changes.

(1) (No change in text.)

(2) Clinical records maintained at the agency shall contain at a minimum the following:

Recodify existing (1) through (6) as (A) through (F) (No change in text.)

(G) A nursing care plan;

(H) Signed and dated progress notes describing recipient's condition; and

(I) Evidence that recipient was given information regarding advance directives.

Recodify existing iii through vi as (3) through (6) (No change in text.)

10:60-2.10 Basis for reimbursement for Model Waiver services

(a) A provider of private-duty nursing services and personal care assistant services shall be reimbursed by the New Jersey Medicaid program on a fee-for-service basis for services provided. Providers shall be precluded from receiving additional reimbursement for the cost of these services above the fee established by the Medicaid program.

1. All costs associated with the provision of private-duty nursing and personal care assistant services by home health agencies shall be included in the routine Medicare/Medicaid cost-reporting mechanism.

(b) (No change.)

(c) Home health services are billed on the UB-82 HCFA-1450 form (see Fiscal Agent Billing Supplement).

(d) See N.J.A.C. 10:60-4 for codes to be used when submitting claims for waiver services for Model Waiver Program, I, II or III.

10:60-2.12 AIDS Community Care Alternatives Program (ACCAP)

(a) The AIDS Community Care Alternatives Program (ACCAP) is a renewable Federal waiver program which offers home and community-based services to recipients with Acquired Immune Deficiency Syndrome (AIDS) and children up to the age of five who are HIV positive.

(b) (No change.)

(c) The program is Statewide with slots allocated to each county based upon the estimated number of AIDS recipients to be served.

(d) (No change.)

10:60-2.14 Eligibility criteria

(a) Recipients eligible for ACCAP shall be:

1. Diagnosed as having AIDS, or be a child up to the age of five who is HIV positive.

2. (No change.)

3. Categorically needy, that is, recipients who are Medicaid eligible in the community, except for those served under the Medically Needy segment of the New Jersey Care ... Special Medicaid Programs; or enrolled in the GSHP or private HMO serving the Medicaid eligible population.

4. (No change.)

(b)-(d) (No change.)

10:60-2.15 ACCAP services

(a) All Medicaid services, except for nursing facility services, are available under ACCAP in accord with an individualized plan of care. Additionally, the following services are available to the eligible recipient:

1. Case management: A process in which a public health nurse or social worker (MSW) in a community agency is responsible for planning, locating, coordinating and monitoring a group of services designed to meet the individual needs of the recipient being served.

i. Special Child Health Units under contract to the New Jersey State Department of Health shall provide case management services to children up to the age of 21.

ii.-iii. (No change.)

2. Private-duty nursing (PDN): Care provided by a registered professional nurse or licensed practical nurse. PDN is continuous rather than part-time or intermittent, provided in the community only, not in an inpatient hospital setting. A nurse shall be employed by a licensed home health agency, voluntary non-profit homemaker/home health aide agency, private employment agency and temporary-help service agency approved by Medicaid to provide PDN services. PDN services *[shall]* ***may*** be provided up to 16 hours per day, per person, but ony when there is a live-in primary adult caregiver who accepts 24-hour per day responsibility for the health and welfare of the individual (see N.J.A.C. 10:60-2.9(b)2 for recordkeeping requirements) unless the sole purpose of the private duty nursing is the administration of IV therapy. *[The maximum of 16 hours includes payment by any source in any 24 hour period.]* ***A minimum of eight hours of hands-on care in any 24 hour period shall be provided by the primary caregiver.***

i. The need for private duty nursing services is established initially by the RSN upon completion of the PAS-1 and HSDP (N.J.A.C. 10:60-1.14(a)). The number of hours of private duty nursing included in the service plan is based upon the recipient's medical need and the cost of service. The total cost of all services provided through ACCAP must be less than the cost of care in an appropriate institution. The need for private duty nursing services and the hours of private duty nursing services may increase or decrease as the recipient's medical status changes, and correspondingly, as the service cost cap changes.

3. (No change.)

4. Personal care assistant service: These are health-related tasks performed in the recipient's home by a certified individual who is under the supervision of a registered professional nurse. These services shall be prescribed by a physician and shall be provided in accord with a written plan of care. Personal care assistant services under ACCAP may exceed the maximum program limitation. Only Medicaid-approved personal care assistant providers shall provide personal care assistant service under ACCAP. All personal care assistants must meet the requirements defined in N.J.A.C. 10:60-1.2.

5. (No change.)

6. Specialized group foster care home for children: This allows for an array of health care services provided in a residential health care program for children from birth to 18 years of age. All children served by the home are under the supervision of the Division of Youth and Family Services (DYFS). Specialized group foster care

home for children services must be prior authorized by the MDO staff, using the FD-352 form (see Appendix A, Fiscal Agent Billing Supplement).

7. Hospice care: This provides optimum comfort measures (including pain control), support and dignity to recipients certified by an attending physician as terminally ill, with a life expectancy of up to six months. Family and/or other caregivers are also given support and direction while caring for the dying recipient. Services shall be provided by a Medicaid approved, Medicare certified hospice agency and available to a recipient on a daily, 24-hour basis. Hospice care shall be approved by the attending physician. Hospice services include: skilled nursing visits; hospice agency medical director services; medical social service visits; occupational therapy, physical therapy and speech-language pathology services; intravenous therapy; durable medical equipment; medication related to symptom control of terminal illness and case management. Reimbursement shall be at an established fee paid on a per diem basis.

(b) Total program costs in ACCAP are limited by the number of community care slots used each year and by costs per recipient. The cost of those recipients' service packages shall be no more than the cost of institutional care for those recipients, determined at a projected weighted cost of institutional care by the Division of Medical Assistance and Health Services.

10:60-2.16 Basis for reimbursement for ACCAP services

(a) A fee-for-service reimbursement methodology shall be utilized for ACCAP waiver service.

(b) The Health Insurance Claim form, 1500 N.J., is used when requesting reimbursement for waiver services provided.

(c) See N.J.A.C. 10:60-4 for codes used when submitting claims for ACCAP.

SUBCHAPTER 3. HOME CARE EXPANSION PROGRAM

10:60-3.1 (No change in text.)

10:60-3.2 Eligibility requirement for HCEP

(a)-(c) (No change.)

(d) An applicant who is eligible for the Community Care Program for the Elderly and Disabled (CCPED) shall be eligible for HCEP if CCPED services are unavailable in the applicant's county of residence.

1. When CCPED services are available in the applicant's county of residence, the applicant shall not be eligible for HCEP.

2. An applicant who is eligible for Medicaid services under the community standard, including New Jersey Care ... Special Medicaid Programs, is not eligible for HCEP.

(e)-(g) (No change.)

10:60-3.3 Services available under HCEP

(a) The seven services provided under HCEP are:

1.-2. (No change.)

3. Homemaker: Personal care, household tasks, and activities of daily living, provided to a beneficiary in the home by a certified homemaker-home health aide employed by either a home health agency or a homemaker agency;

4.-7. (No change.)

(b)-(d) (No change.)

Recodify existing N.J.A.C. 10:60-4.4 and 4.5 as 3.4 and 3.5 (No change in text.)

10:60-3.6 Termination from HCEP

(a) Beneficiaries shall be terminated from HCEP if:

1.-2. (No change.)

3. He or she is determined financially eligible for Medicaid benefits;

4. He or she is assessed as no longer in need of long-term home care services;

5. His or her cost-share payments are not paid in full for two consecutive months; or

6. He or she is determined eligible for CCPED and services are available in the applicant's county of residence.

(b) (No change.)

(c) A beneficiary terminated from HCEP shall be billed by the Bureau of Pharmaceutical Assistance to the Aged and Disabled for services rendered during a period of ineligibility.

(d) (No change.)

(e) A beneficiary who is terminated from HCEP participation may exercise his or her right to appeal the decision by submitting a request for a fair hearing in accordance with N.J.A.C. 10:49-9.10. Such request shall be submitted within 20 days from the date of the letter of termination.

1.-2. (No change.)

(f) (No change.)

SUBCHAPTER 4. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:60-4.1 (No change in text.)

10:60-4.2 HCPCS Codes

(a) (No change.)

(b) Community Care Program for the Elderly and Disabled (CCPED) and Home Care Expansion Program (HCEP)

HCPCS CODE	DESCRIPTION
Z1240	Case Management, per recipient, per month

1. The following codes are to be used by licensed Home Health Agencies ONLY

Z1245 to Z1339 (No change.)

2. The following codes may be used by licensed Home Health Agencies or Homemaker Agencies

Z1200 to Z1235 (No change.)

W9002 Medical Day Care, daily

3. In addition to the above, the following are appropriate to HCEP only and used only by HCEP case managers

Z1202 Initial Comprehensive Needs Assessment

Z1203 Collection of Disability Information

(c)-(d) (No change.)

SUBCHAPTER 6. (RESERVED)

APPENDIX A
FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Paramax/Unisys Corporation
CN 4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN 049
Trenton, New Jersey 08625-0049

(a)

DIVISION OF FAMILY DEVELOPMENT

Program Administration

Programs Administered/Supervised by the Department of Human Services

Adopted New Rules: N.J.A.C. 10:84

Proposed: December 21, 1992 at 24 N.J.R. 4480(b).

Adopted: November 1, 1993 by William Waldman, Commissioner, Department of Human Services.

Filed: November 3, 1993 as R.1993 d.611, **with changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4B-2 and P.L. 1990, c.66, effective July 1, 1991.

Effective Date: January 18, 1994.
Expiration Date: January 18, 1999.

Summary of Public Comments and Agency Responses:

The Department received comments from five individuals: Melinda Carlton, Board of Chosen Freeholders of the County of Warren; Carol Pirrotta, County Welfare Director's Association; Beverly Bearmore, Ocean County Board of Social Services; Thomas J. D'Alessio, Office of the County Executive, Essex County; and Robert M. Fasanello, Hunterdon County Board of Social Services. The Department also received a request for a public hearing; however, inasmuch as the request for the public hearing was not timely, a public hearing was not held. It may be noted that rules concerning the same issue were first proposed in the June 3, 1991 issue of the New Jersey Register at 23 N.J.R. 1740(a). As a result of that proposal, a public hearing was held on August 21, 1991 and both written and oral comments received pursuant to that proposal/public hearing were considered.

COMMENT: The standards and criteria to be used by the Commissioner in judging when a county welfare agency (CWA) is deficient are not enumerated nor defined. Those factors at N.J.A.C. 10:84-1.2 are vague and do not constitute specific standards.

RESPONSE: Because of the broad spectrum of services provided by the CWAs, there are endless specific situations to which the rules may be applicable. The proposed rule provides the guidelines necessary and appropriate when used in conjunction with the Division's Program Review Guide, which contains elements of eligibility from N.J.A.C. 10:81 and 10:82. The Guide contains current Federal and State regulatory requirements and reviews only those aspects of a CWA's operation which impact directly upon our clients. As the program changes, the Department will need some flexibility to deal with other review elements as existing programs change or new programs are implemented, with corresponding regulatory changes.

COMMENT: The rule should also address that a State takeover of an agency not be a permanent situation. A limitation should be placed on the length of time that the Commissioner can maintain control of the agency. The conditions and process by which control may revert back to the county should be clearly outlined, with time frames within which the county can request that control be returned.

RESPONSE: The period of time during which the Department of Human Services will maintain control of CWA operations will be dependent upon the problem(s) identified which led to the assumption of such activity. Of course, once all identified deficiencies are rectified and client services are no longer in jeopardy, operation of the county agency will be returned to the appropriate administrative body.

COMMENT: N.J.A.C. 10:84-1.3(b)5ii(2)(D) and 1.5, concerning the fair hearing process, are inappropriate. The Commissioner of Human Services cannot fairly render a final decision on an appeal by a CWA from the Commissioner's administrative determination to assume the direct administration of a county operation. Disputes regarding takeover between a CWA/county and the Department of Human Services would be more fairly resolved by a Trial Court Tribunal whose decision is not subject to executive agency affirmance, reversal or modification. It was also suggested that the dispute could be sent to an impasse panel or a third party mediator with an appropriate appeal process for either party.

RESPONSE: These rules were developed in accordance with the provisions of N.J.A.C. 1:1, established by the Office of Administrative Law. While it is true that the Commissioner may overturn a decision of an administrative law judge, a county may certainly appeal to a higher level of legal review and there is certainly no prohibition from the Commissioner being enjoined by a court of competent jurisdiction from taking action to assume CWA operations.

COMMENT: Since counties administer other programs aside from public assistance, in the event that a takeover becomes necessary due to deficiencies in the administration of public assistance programs, mechanisms for a partial takeover should be available, especially if other welfare agency programs in that county are being adequately administered.

RESPONSE: As indicated at N.J.A.C. 10:84-1.4, the Commissioner shall have the authority to "Make the administrative and programmatic changes necessary to ensure compliance with State and Federal law and regulations." In the event that a takeover becomes necessary due to deficiencies in the administration of public assistance programs, the Commissioner may not need to take over all welfare programs in order to correct such deficiencies. The Commissioner will use his or her discretionary authority to do so.

COMMENT: Time frames for corrective action and compliance are determined in accordance with N.J.A.C. 10:84-1.2(a)3 and 1.3(b)3 and provide that failure to meet the requirements within the time frames is considered evidence of noncompliance. In view of the potential takeover of a CWA for noncompliance, a mechanism is needed for the mutual, as opposed to unilateral, establishment of appropriate time frames to resolve program problems.

RESPONSE: The Department disagrees and takes the position that while the corrective actions themselves are an item for negotiation, establishing the time frame(s) for executing a mutually agreed upon corrective action plan rests solely with the Department. Establishing specific time frames for executing a mutually agreed upon corrective action plan cannot be developed. The Department is dealing with too many different situations and variables. For example, depending on the size of the CWA and also number of employees, while it may take one CWA three days to come up with a solution, another CWA may need twice as long. There may be other variables that may come into play which cannot be anticipated.

COMMENT: N.J.A.C. 10:84-1.4, which requires deductions from a county's final appropriations when certain services or functions of the CWA are assumed by the Department of Human Services, exceeds the scope of authority granted to the Commissioner by Public Law 1990, Chapter 66.

RESPONSE: After further review of Public Law 1990, Chapter 66, the Department has amended N.J.A.C. 10:84-1.4(a) to reflect such language, since the rule as proposed does not comport with that law.

COMMENT: Under what circumstances "may" a CWA be billed and under what circumstances will the CWA be exempt from paying for a State takeover?

RESPONSE: Such a decision can only be made on a case-by-case basis, depending on the severity of the problems encountered, number of staff and length of time required for resolution, and so forth.

COMMENT: A distinction should be made between "voluntary" takeover (that is, where local officials willingly seek State assistance in administering the local welfare program) and "involuntary" takeovers, which are adversarial.

RESPONSE: The Department does not feel that distinction should be made between "voluntary" and "involuntary" takeovers, since the desired outcome of both is the same, that is, the effective and efficient administration of public assistance programs to ensure that clients, who are dependent on public assistance benefits, live in a humane and healthy manner.

COMMENT: At N.J.A.C. 10:84-1.1(b), specific incentives should be offered for performance above the norm.

RESPONSE: While the Department does not disagree with the commenter, the intent of the proposed new rule at N.J.A.C. 10:84-1.1 is to set forth in the New Jersey Administrative Code the obligation and authorities of the Commissioner which, in accordance with P.L. 1990, c.66, provides for the Commissioner to assume direct administration of county welfare operations in situations in which a county agency has failed to follow applicable State and Federal laws and regulations. Making revisions to the rule to include "incentives" at time of this adoption would constitute a "substantial change" under the Administrative Procedure Act of such a nature as to require a reproposal. In addition to requiring a reproposal, it should be noted that this issue is one that would involve further research, not only with respect to what incentives can be provided, but what funding, if any, may be available for such incentives.

COMMENT: The wording at N.J.A.C. 10:84-1.1(d), as proposed, seems to deviate from the wording and intent of Public Law 1990, Chapter 66. The rule attempts to expand the Commissioner's powers further than intended by the cited Law with respect to mandating that the CWA follow State/Federal regulations.

RESPONSE: After further review of Public Law 1990, Chapter 66, and N.J.S.A. 30:1-12(b)(2), the Department disagrees with the commenter and asserts that the rule, as proposed, does indeed reflect both the language and intent of the law as it currently appears at N.J.S.A. 30:1-12(b)(a). The law recognizes that a CWA can be following State/Federal regulations but may not be effectively administering the program. If the CWA is not effectively administering the program, which could therefore affect the client(s), the Commissioner has been given the authority to step in as provided at N.J.S.A. 30:1-12(b)(2).

COMMENT: At N.J.A.C. 10:84-1.1(d), there is an omission: the statute's qualifier that the substantial failure to comply with law results in placing clients "at serious risk." Unless the clients are "at serious risk" the authority cannot be invoked.

RESPONSE: The Department agrees with the commenter and has amended text at N.J.A.C. 10:84-1.1(d), to comport with the language as written in Public Law 1990, Chapter 66.

COMMENT: At N.J.A.C. 10:84-1.2(a) and (a)1, concerning unlawful activities, the rule appears to impose a more severe action than that allowed under "civil service" procedures and is possibly in violation of civil rights as well.

RESPONSE: When there is sufficient evidence to warrant removal of the individual from the situation in which an unlawful activity is indicated, the Department believes that the agency must take remedial action. The new rule is not intended to violate anyone's civil rights, or the Department of Personnel rules, but when there is evidence for these actions, it is most prudent and good public policy to mandate such action to ensure that, as provided under P.L. 1990, c.66, programs that serve eligible low-income persons administered by counties throughout the State are provided to eligible persons in an accessible, efficient, and cost-effective manner. This may include, depending upon circumstances, only the temporary reassignment of an individual to another work unit or, should the situation warrant, suspension or even removal, as appropriate.

COMMENT: The proposed new rules should be rewritten in consultation with those designated to assist in the takeover process in order to come up with clear, precise, objective, fair, and accurate expression of the meaning of the law.

RESPONSE: The Department notes that these rules, prior to proposal, were in fact developed by Department staff, in conjunction with representatives from a number of the CWAs. Such representatives were given the opportunity prior to proposal to review/comment on the subject rules and those comments were considered in the final development of these rules.

Full text of the changes between proposal and adoption follows (additions to proposal indicated in boldface with asterisks ***thus***):

CHAPTER 84
PROGRAM ADMINISTRATION

SUBCHAPTER 1. EFFICIENCY AND EFFECTIVENESS OF PROGRAM OPERATIONS

10:84-1.1 Authority of the Commissioner under P.L. 1990, c.66

(a) The Commissioner of the Department of Human Services (DHS) is obligated to ensure that programs that serve eligible low-income persons administered by counties throughout the State are provided to eligible persons in an accessible, efficient, and cost-effective manner.

(b) The Commissioner has the authority to establish rules, regulations, and directives, including incentives and sanctions, to ensure that county agencies provide benefits to eligible recipients in a manner consistent with State and Federal law.

(c) The Commissioner shall have the authority to review and approve CWA budgets.

(d) The Commissioner shall have the power to assume direct administration of all county welfare agency operations in situations in which the Commissioner determines that a county agency is failing to effectively administer or to substantially follow State and Federal law in its administration of those programs for which the Department of Human Services has responsibility***, thereby placing clients, who are dependent on public assistance benefits, at serious risk***.

10:84-1.2 Factors prompting the assumption of county operations

(a) The following are factors viewed as particularly significant program irregularities and management deficiencies. Elements such as unlawful activity, pervasive fiscal and/or program deficiencies are the primary basis for consideration of assumption action. Failure on the part of the county to correct any such deficiency so identified by the Department will result in the ultimate administrative takeover of program administration by the Department.

1. Unlawful activity refers to arrest, indictment or conviction by a court of law of any senior official of a county welfare agency, county welfare board or other appropriate county welfare agency governing body for abuse(s) related to public assistance program administration. Unlawful activity includes, but is not limited to, fraud, theft, perjury, removal, alteration or destruction of public records, other similar wrongdoing, or willful misuse of public assistance funds. Failure of the agency to remove such individual from the situation which enabled the unlawful activity shall be considered as evidence of noncompliance.

2. Fiscal operations irregularities or management deficiencies refer to absence of adherence to State and Federal fiscal procedures and regulations relating to public assistance administration. Inaudible fiscal records shall be interpreted as evidence of noncompliance if the agency fails to effect corrective action within specified timeframes.

3. Program operations irregularities or management deficiencies refer to persistent and pervasive failure on the part of the county welfare administrative agency to safeguard the confidentiality of its clients; or to regard an individual's civil rights in the administration of public assistance benefits and services; or to correctly determine program eligibility and/or timely and accurate benefit issuance in accordance with State and Federal program regulations and procedures. Failure on the part of the agency to take corrective action on deficiencies, identified based on a program audit, within specified timeframes shall be considered evidence of noncompliance.

10:84-1.3 Corrective action plans

(a) The Department shall afford a county welfare administrative agency reasonable opportunity to correct identified deficiencies before assuming administration for violations as set forth in N.J.A.C. 10:84-1.2.

(b) The corrective action or resolution procedure will be comprised of a multi-step process to include, but which is not limited to:

1. Identification of Departmental findings of deficiencies and notification to the county agency of the need to take corrective action;

2. Convening of one or more conferences of Departmental and county agency personnel to identify possible causes of the deficiencies in CWA operations and negotiation of appropriate corrective actions;

3. Development, submittal and implementation of an approved corrective action plan by the CWA to improve CWA operations, within the time periods specified by the Department, to correct the identified deficiencies;

4. Upon implementation of the corrective action plan, monitoring of CWA operations by the Department to verify that planned corrective actions are taking place as stipulated; and

5. Reassessment by Department staff of the CWA's operations at the end of the designated period.

i. CWAs that have effected the corrective actions required for the identified deficiency shall be so notified and shall no longer be subject to the corrective action requirement for that deficiency which has been satisfactorily resolved.

ii. CWAs which have failed to effect required corrective action within the specified time frame or failed to show a good faith effort toward corrective action shall be subject to the following:

(1) The Department shall provide written notification of its findings and convene a meeting with representatives of the CWA, county welfare board or other appropriate CWA governing body, and the county governing authority to discuss any unresolved deficiencies.

(2) When it is determined that, after meeting with representatives of the CWA, county welfare board or other appropriate CWA governing body, and the county governing authority, barriers for improvement remain and cannot be resolved, the Department shall advise, in writing, all parties involved of its intent to assume direct administration of county operations in accordance with N.J.A.C. 10:84-1.4. That written notification shall include:

(A) The basis for the assumption action;

(B) The date the assumption will commence;

(C) A statement advising the county that it shall be responsible for the payment of reasonable expenses incurred by the Department to make administrative and/or programmatic changes necessary to

ensure that the CWA's operations are provided in an effective and efficient manner and comply with State and Federal law and regulations; and

(D) A statement concerning county appeal rights advising the CWA of its right to request a State fair hearing in writing, which must be postmarked within 10 days of the mailing date of the notice of assumption (see N.J.A.C. 10:84-1.5 concerning State fair hearings).

10:84-1.4 State assumption of direct administration of county operations

(a) For each fiscal year, or portion thereof, in which a service or function associated with the provisions of P.L. 1990, c. 66, is assumed by the Department, the county shall deduct from its final appropriations upon which its permissible county tax levy is calculated the amount which the county expended for that service or function during the last full budget year, or portion thereof*, **for which the service or function so transferred was funded from appropriations in the county budget***. If the Commissioner determines that any county welfare agency has failed to effectively administer or to substantially follow State and Federal law in its administration of those programs for which the Department of Human Services has responsibility, the Commissioner shall have the authority to take the following actions:

1. Make the administrative and programmatic changes necessary to ensure compliance with State and Federal law and regulation;

2. Bill the county for the reasonable expenses incurred by the Department in ensuring compliance;

3. Hire any consultant or undertake any studies of the agency's operations deemed appropriate;

4. Direct expenditures of the CWA in a reasonable and prudent manner to effectuate the purposes of any public assistance program, including reallocating funds within the CWA budget and determine additional amounts of revenue needed to ensure the efficient and effective administration of such programs within the agency's budget;

5. Operate the CWA; and

6. Do all acts necessary or appropriate to ensure that the needs of eligible public assistance recipients are met pursuant to State and Federal law.

10:84-1.5 State fair hearings for State assumption of CWA operations

(a) Any county that wishes to appeal a decision by the Department concerning State assumption of the CWA's operations is entitled to request a State fair hearing within 10 days of the date postmarked on the envelope containing the notice of State assumption of operations. The request shall be made, in writing, to DFD's Bureau of Administrative Review and Appeals (BARA) by the CWA director, president of the county welfare board or by a representative of the county governing authority.

1. When a request is received by BARA, it shall immediately be registered as of that date.

2. All assumption hearing requests shall be transmitted to the Office of Administrative Law (OAL) for a hearing before an Administrative Law Judge (ALJ).

3. The OAL shall schedule the State assumption hearing and send any necessary notices to all appropriate parties concerned. The hearing shall be in accordance with the provisions of N.J.A.C. 1:1.

(b) A final administrative hearing decision shall be rendered by the Commissioner of the Department of Human Services or his or her designee. All parties to the matter shall be notified by mail of any decision or order. The final decision shall be effective on the date of issuance.

1. The county may appeal the final decision rendered by the Commissioner or designee through the Appellate Division of the Superior Court; however, such appeal shall not delay implementation of the final decision.

(a)

DIVISION OF FAMILY DEVELOPMENT

Food Stamp Program

Readoption with Amendments: N.J.A.C. 10:87

Proposed: October 18, 1993 at 25 N.J.R. 4697(b).
Adopted: December 17, 1993 by William Waldman, Commissioner, Department of Human Services.
Filed: December 21, 1993 as R.1994 d.42, **without change.**

Authority: N.J.S.A. 30:4B-2, 7 CFR Parts 271, 272, 273, 274, 275, and 278; and the Americans with Disabilities Act (P.L. 101-336).

Effective Date: December 21, 1993, Readoption;
January 18, 1994, Amendments.
Expiration Date: December 21, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 10:87.

Full text of the adopted amendments follows:

10:87-1.11 Policy of nondiscrimination

CWAs shall not discriminate against any applicant or participant in any aspect of program administration, including, but not limited to, the certification of households, the issuance of coupons, the conduct of fair hearings or any other program service, for reasons of age, race, color, sex, disability, religious creed, national origin or political belief.

10:87-1.12 Complaint procedures

(a)-(c) (No change.)

(d) If a person alleges verbally that a discriminatory act has been committed and does not (or cannot) put it in writing, the CWA worker receiving the complaint shall do so. If possible, the following information shall be obtained from the complainant:

1.-3. (No change.)

4. Reason: The reasons for the alleged discrimination (i.e., age, race, color, sex, disability, religious creed, national origin or political belief);

5.-6. (No change.)

(e) (No change.)

10:87-8.12 Hearing procedures

The hearing shall be conducted pursuant to the Special Hearing Rules for Division of Family Development cases, N.J.A.C. 1:10, and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

10:87-8.13 (Reserved)

10:87-8.15 Household rights

(a) The household shall have the following rights:

1. Examination of documents: Prior to and at the time of the hearing, the household shall have the right to examine all documents and records which are to be used during the hearing.

2. Contents of case record: The contents of the case record, including the application form and documents of verification used by the CWA to establish the household's ineligibility or eligibility and allotment, shall be made available, provided that confidential information such as the names of individuals who have disclosed information about the household without its knowledge or the nature or status of pending criminal prosecutions is protected from release. Free copies of relevant portions of the case record shall be furnished if requested by the household or its representative.

3. Confidential information: Confidential information which is protected from release and other documents or records which the household will not otherwise have an opportunity to contest or challenge shall not be introduced at the hearing or affect the hearing official's decision.

10:87-8.17 (Reserved)

10:87-8.18 (Reserved)

10:87-8.19 (Reserved)

10:87-8.20 Decision on fair hearing

Effective date of decision: The fair hearing decision shall be effective on the date of final decision unless another effective date is designated in the final fair hearing decision.

10:87-11.7 Administrative disqualification hearing procedures

(a) Administrative disqualification hearings will be conducted pursuant to the Special Rules for Division of Family Development cases, N.J.A.C. 1:10, and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) Hearings will be scheduled by the Office of Administrative Law (OAL) and will be conducted by an administrative law judge assigned by the Director of OAL.

(c)-(e) (No change.)

(f) Advance notice of hearing: The CWA shall provide written notice to the household member suspected of intentional program violation at least 30 days in advance of the date an administrative disqualification hearing has been scheduled. The notice shall be mailed by certified mail—Return Receipt Requested.

1. The advance notice shall contain at a minimum:

i.-vi. (No change.)

vii. A listing of the household member's rights to:

(1) Examine documents and records under the requirements of N.J.A.C 10:87-8.15(a)1;

(2) Present the case or have it presented by a legal counsel or other person;

(3) Bring witnesses;

(4) Advance arguments without undue interference;

(5) Question or refute any testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses;

(6) Submit evidence to establish pertinent facts and circumstances in the case.

viii.-ix. (No change.)

2. (No change.)

10:87-11.9 (Reserved)

(a)

COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

BUSINESS ENTERPRISE PROGRAM

Business Enterprise Program License

Adopted Amendments: N.J.A.C. 10:97-1.3 and 3.1

Proposed: October 4, 1993 at 25 N.J.R. 4551(d).

Adopted: December 10, 1993 by William Waldman, Commissioner, Department of Human Services.

Filed: December 13, 1993 as R.1994 d.27, **without change.**

Authority: N.J.S.A. 30:1-12, 30:6-15.1 and 15.2, 20 U.S.C. 107 et seq., 34 CFR 395.

Effective Date: January 18, 1994.

Expiration Date: May 15, 1994.

Full text of the adoption follows:

10:97-1.3 Definitions

The following words and terms shall have the indicated meanings, unless the context clearly indicates otherwise:

...

"License" means a written instrument issued by the State licensing agency to a blind person authorizing such person to operate a vending facility on Federal or other property.

...

10:97-3.1 Completion of probation period and license

(a)-(d) (No change.)

(e) If a permit authorizing a business to be established in a specific location is terminated, the operating agreement is terminated. However, if termination is through no fault of the operator, he or she will be eligible to apply for subsequent promotion and transfer opportunities, under conditions set forth in N.J.A.C. 10:97-7.3.

INSURANCE

(b)

DIVISION OF PROPERTY AND CASUALTY

Automobile Insurance: Rate Filing Requirements for Voluntary Market Private Passenger Automobile Insurance

Adopted Amendment: N.J.A.C. 11:3-16.10

Proposed: September 20, 1993 at 25 N.J.R. 4436(a).

Adopted: December 22, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Filed: December 22, 1993 as R.1994 d.46, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1C-6(e) and 17:29A-1 et seq.

Effective Date: January 18, 1994.

Expiration Date: January 4, 1996.

Summary of Public Comments and Agency Responses:

The proposed amendment was published on September 20, 1993 at 25 N.J.R. 4436(a). During the comment period which closed October 20, 1993, comments were received on behalf of 10 commenters including insurance companies (Keystone Insurance Company, Liberty Mutual Insurance Group, the New Jersey Personal Automobile Insurance Plan ("PAIP"), Prudential Property and Casualty Insurance Company of New Jersey, Selective Insurance Group Inc., State Farm Insurance Companies and United Services Auto Association ("USAA")) an insurance trade association (AIPSO), a producer trade association (Professional Insurance Agents of New Jersey) and the Department of the Public Advocate, Division of Rate Counsel. Their comments and the Department's responses are summarized below:

COMMENT: Keystone Insurance Companies took exception to being categorized on Exhibit H, as marketing its product through captive agents. The insurer requested its reclassification on the exhibit as marketing through independent agents, based on the fact that it markets its automobile insurance through agencies of member clubs of the American Automobile Association ("AAA"). The commenter stated that the club agencies with whom Keystone conducts business do not have a reciprocal arrangement and they are able to sell products underwritten by any insurer.

Keystone also noted that while currently the club can only place their automobile risks with Keystone, that was not the case in prior years and it may not be the case in future years. Keystone claims it does not control that decision and it must compete with other insurers for the business placed by the club.

RESPONSE: The Department disagrees that Keystone should be classified as marketing through independent agents because, as Keystone noted, AAA club agencies currently can only place automobile risks with Keystone. However, if in the future AAA changes its agreement with Keystone, Keystone may file sufficient documentation with the Department to substantiate that it should be reclassified. The Department will, at that time, reconsider Keystone's classification.

COMMENT: One commenter opposed the limitation of expense ratios to an industry average because doing so implies that companies with above average expense ratios are inefficient. The commenter stated that because of large differences between insurers national vs. regional, large vs. small, multi-line vs. single-line, it is simplistic to assume that all insurers would operate at the same expense ratios. The commenter claimed that insurers with above average expense ratios will be forced out of the New Jersey insurance market.

RESPONSE: The commenter's objection is beyond the scope of this amendment. The Department's rules already limit expense ratios in the

standard ratemaking methodology. This amendment merely categorizes insurers in a manner which provides for a more equitable comparison.

COMMENT: Several commenters supported the proposed amendment and acknowledge that the change will result in a more accurate comparison of acquisition and general expenses.

One commenter noted that the current requirement, utilizing a comparison of similarly organized insurers, is inequitable to insurers which use the professional agency system to distribute and service their products because the industry average includes data from all varieties of companies including insurers which are direct writers. For companies which are direct writers, expense factors comparable to commissions may be reflected elsewhere, such as in salaries, payroll taxes and employee benefits. The averages for these companies would, therefore, be artificially low compared to the average for insurers which use independent agents.

By failing to account for insurers' marketing systems the above-noted scenario produces an unjust result in the computation of expenses. The commenter therefore supports the proposal which determines the historic expense provision by comparing Best's percentages for insurers that use similar marketing techniques.

RESPONSE: The Department in general agrees with this commenter.

COMMENT: Liberty Mutual Fire Insurance Company ("Liberty Mutual") opposed its classification as a company which utilizes direct writers. It stated that its marketing greatly differs from that of the other direct writers listed in Exhibit H, New Jersey Manufacturers ("NJM") and USAA. Liberty Mutual markets through sales offices throughout the State and markets to the general public. Liberty Mutual stated that neither NJM nor USAA maintain sales offices nor market to the general public. Liberty Mutual claimed that its marketing methods more closely resemble those of State Farm Mutual and Allstate, that its acquisition expenses are more similar to these companies and, therefore, it should be categorized as utilizing captive agents.

RESPONSE: The Department disagrees with this commenter. At the time Exhibit H was promulgated, Liberty Mutual's commission expenses on New Jersey rate filings were more similar to those of NJM and USAA than of the captive agent companies set forth on Exhibit H. The Department will reevaluate any information which Liberty Mutual may file in the future, which demonstrates that it should be recategorized.

COMMENT: One commenter stated that it is a "one-state company," and, therefore, claimed that it will be placed at an unfair disadvantage by being categorized with other insurers which utilize captive agents. The commenter claimed that the other insurers in its category, which operate country-wide, enjoy an economy of scale not available to the commenter. The commenter noted that several other insurers which utilize captive agents have their home offices in the mid-west, which is a less expensive region of the country than New Jersey. Thus, the commenter reasoned that it will be placed at an unfair disadvantage in obtaining rate relief.

RESPONSE: The Department disagrees that any change is necessary or appropriate. The commenter does not disagree that its method of marketing is that of a "captive agent" company, but merely asserts that there are differences based on size and geographical territory served among insurers within that classification. These kinds of differences will exist regardless of the nature of the classification, and affect the relative comparison of a particular insurer's expenses with the average of all insurers in the class. The Department, therefore, finds that there is no need to define the classes more narrowly. To do so would adversely impact on the rule's intent to employ averages of classes large enough to be meaningful.

The Department notes that this rule is part of the standard ratemaking methodology used for the evaluation of individual rate filings. N.J.A.C. 11:3-16.10(f) authorizes a rate filer to suggest a superior, alternate procedure "in total or in part" when making a filing.

COMMENT: One commenter urged the Department to realize that any time an average is used, there will be companies both above and below the average and capping expenses at the group average could result in companies with higher expenses losing money which will eventually want to leave the market.

RESPONSE: The Department has utilized an "average" recognizing that the average accounts for insurers which are both more and less efficient. The Department, therefore, considers the average to be a reasonable standard.

COMMENT: Several commenters opposed the capping of expenses. The commenters believe that rates should reflect all costs which are expected to be incurred during the period rates are in effect. One commenter stated that the current procedure ignores certain factors which prevent the procedure from distinguishing between efficient and inefficient companies as intended by the rule.

RESPONSE: N.J.S.A. 17:29A-36.2a(3) provides that the Commissioner shall promulgate rules which establish "standards of efficiency and standards of measure based upon industry-wide aggregate averages and other relevant data and facts to be utilized in the review and evaluation of the loss expense and financial data contained in a rate filing. . . ." As noted above and as authorized by N.J.S.A. 17:29A-36.2a, the Department currently caps expenses. These amendments merely provide a better and more equitable method to compare insurers' expense factors.

COMMENT: While one commenter opposes expense capping, it, nevertheless, supports the comparison of insurers based on insurer marketing systems. The commenter stated that this approach improves the comparison of the company expense ratios because it addresses similarities among company operations.

RESPONSE: The Department agrees that the proposed amendment more accurately compares similarities among company operations which the current rule does not address.

COMMENT: One commenter stated that the data contained in Best's Aggregates and Averages is based on nationwide expenses, rather than New Jersey specific expenses. The commenter suggested that the use of Best's data may result in the understating of the expense provision needed in New Jersey automobile insurance rates since expenses in New Jersey are higher than expenses in other states. The commenter, therefore, suggested that this fact lends support to the use of actual expense figures in ratemaking calculations.

RESPONSE: This comment is beyond the scope of the amendment. The Department currently requires insurers to use Best's data in their calculations. This amendment only changes how insurers will be compared.

COMMENT: One commenter suggested that the proposed amendment inhibits rather than promotes open market competition. The commenter stated that the proposed method is unfair to companies which have higher than average expense ratios but provide better than average service; that their insurers will be encouraged to cut back on their services because they cannot recover their legitimate expenses in their rates; that higher than average expenses may be beneficial to consumers to the extent that they are the result of loss prevention activities; and that expenses for loss prevention activities may actually result in lower rates to consumers. The commenter suggested that if market forces were permitted to reenter the New Jersey private passenger automobile insurance market, competition would hold down expenses and rates.

RESPONSE: As noted above, N.J.S.A. 17:29A-36.2a(3) requires the Commissioner to set standards for the calculation of expenses to be used in the Department's standard ratemaking methodology. Standards based on averages are in the present rule. These comments are, therefore, beyond the scope of this amendment.

COMMENT: One commenter agreed that if an expense limitation is used, the proposed categories are more appropriate than the categories currently in use. However, the commenter stated that because insurers may categorize expenses differently, there is a significant problem with the rule. The commenter urged that if an expense limitation is to be used, it should apply to the total of commission, other acquisition and general expenses, not separately to each component.

RESPONSE: The Department notes that the expense limitation in N.J.A.C. 11:3-16.10(b)6 does apply to "commission and brokerage other acquisition expenses and general expenses on a combined basis."

COMMENT: One commenter opposed the proposed amendment because it fails to consider the reasonableness of individual insurer expenses. The commenter suggested that insurer expenses should be reviewed individually in relation to the level of service, classes of business served and other operating characteristics rather than arbitrary comparisons to other insurers.

The commenter also stated that the amendment unfairly discriminates against efficient, direct writers by holding them to a more stringent standard.

RESPONSE: The Department's preferred ratemaking methodology procedures are set forth at N.J.A.C. 11:3-16.10(a) through (e). However, the Department notes that N.J.A.C. 11:3-16.10(f) permits an insurer to propose an alternate procedure in whole or in part, provided that the procedure is supported by such calculations and other information it deems appropriate to demonstrate the superiority of the alternate procedure in determining its rates.

COMMENT: A commenter objected to the fact that the proposed regulation fails to consider the nature of fixed expenses by comparing all expenses to premium. The commenter also claimed that differences in rate levels which exist among insurers would also distort comparisons of expenses relative to premiums. Insurers with a higher rate level, all other things being equal, would appear to have a lower expense ratio when compared to insurers with a lower rate level. The commenter suggested that the use of fixed expenses is a fair and equitable way to share costs among members.

RESPONSE: The rule, which includes the standard of comparing expenses to premiums, has been in effect since February 5, 1990. This amendment merely establishes a better method to compare insurer expenses.

COMMENT: One commenter suggested that differences in expense provisions should be encouraged because differences exist for valid business reasons. The commenter claimed that any attempt to minimize existing differences will have social and economic impacts; certain segments of the insurance market will be affected by the lack of availability if restrictions in rate levels result from enforcement of the regulation; and insurers may be prohibited from earning an adequate rate of return.

RESPONSE: This comment is beyond the scope of this amendment for the reasons stated in response to previous comments.

COMMENT: Two commenters stated objections with regard to the application of the rule to the Personal Automobile Insurance Plan ("PAIP") because:

(1) The expenses for processing and servicing policies are prescribed by the PAIP Plan of Operation are independent of the legal organization and or marketing approach of the insurer receiving a PAIP assignment;

(2) Hispanic expense experience is not relevant for rate-making purposes because the commission rate and rules set forth in the PAIP Plan of Operation apply uniformly and prospectively to all agents and brokers; and

(3) General and other acquisiton expenses for the PAIP need to be examined separately from the combination of commission and brokerage, other acquisition expenses and general expenses.

The commenters also stated that because of the nature of PAIP business, processing and servicing expenses exceed those for similar voluntary market business. For example, the commenters noted that the cancellation rate for involuntary market business significantly exceeds that for similar voluntary market policies. The excess cancellation rate is largely attributable to non-payment of premium. As a result, the pro-rata cancellation table must be used and no expense benefit occus when applying the short-rate table. Insurers must also be prepared to deal with every licensed agent in the State as opposed to its own agency force.

RESPONSE: The Department notes that N.J.A.C. 11:3-16.1(6) states that the subchapter applies to all insurers making private passenger automobile insurance rate filings for the voluntary market in New Jersey. Currently PAIP filings are governed by N.J.A.C. 11:3-2.9 and the PAIP Plan of Operation. Any changes to PAIP rate filings shall, therefore, be governed by amendments to N.J.A.C 11:3-2.9 or the Plan of Operation.

COMMENT: A commenter felt that the proposed amendment is ambiguous with regard to the manner in which the maximum expense provision is to be calculated. The commenter wanted clarification as to whether a simple average of the companies or a weighted average is to be used.

The commenter also suggested that the list of 20 insurers was insufficient and that use of only a few companies in each category could lead to inappropriate and unfair results. The commenter suggested that the list should be expanded to the top 100 companies writing private pasenger automobile insurance in New Jersey.

Another commenter stated that the number of insurers listed was insufficient to provide a meaningful sample of averaging.

RESPONSE: The 20 insurers listed in Exhibit H comprise approximately 80 percent of the market based on 1992 premiums written. The Department has determined that expenses shall be calculated on a weighted average and has made this clarification to the amendment. Therefore, based on these factors, the list of 20 insurers set forth in Exhibit H is sufficient. Because these 20 insurers comprise the overwhelming majority of the market, increasing the list to the top 100 insurers will not significantly alter the results in calculating expenses.

COMMENT: One commenter stated that the proposal contained three flaws:

(1) Four companies listed on Exhibit H to the Apendix are not listed in the 1993 edition of Best's Aggregates and Averages: Keystone Insurance Co. of NJ, Aetna Casualty & Surety Company, Atlantic Employers Insurance Co. and Continental Insurance Co. of NJ. The commenter suggested that if these are new companies they should be excluded from the exhibit because their expenses would not be representative since start-up expenses for new companies will not reoccur in the future. However, if these companies have merely been renamed, the Department should provide the former company names for reference purposes.

(2) An insurer's ability to select other insurers with similar marketing systems as long as they include those listed in Exhibit H, will provide varying results and may result in biased upward values where insurers select other companies with high expenses. This ambiguity in the proposal means that there is no set benchmark for each insurer.

The commenter, therefore, suggested 20 insurers listed should have at least three years of experience in New Jersey based on the premium volume reported in their annual statements. The commenter also suggested that insurers should be limited to the use of the insurers set forth in Exhibit H.

(3) The proposal does not specify how to average the expense provisions of insurers with the same marketing systems. Averages could either be simple averages or weighted averages. Weighted averages can be based on different weights such as country-wide net written premiums or net written premiums for the State.

The commenter proposed to resolve these problems with amending paragraph (b)6 as follows:

In determining the historic expense provision for commission and brokerage, other acquisition expenses and general expenses on a combined basis, the percentage to premium for each year of experience shall be limited to a maximum of the *weighted average of the *percentage*(s)* shown in "Best's Aggregates and Averages" for the same period for [comparable property/casualty insurance companies. If a stock company, the filer shall use the percentage for stock companies; if a mutual company, the filer shall use the percentage for mutual companies; and if a reciprocal company, the filer shall use the percentage for reciprocal companies.] property/casualty insurance companies which most closely approximate the insurer's method of marketing automobile insurance as set forth in Exhibit E to the Appendix, incorporated herein by reference. If an insurer uses salaried employees which deal directly with the public, the filer shall use the *weighted average* percentage for insurers which use salaried employees which deal directly with the public; if an insurer uses exclusive agents, the filer shall use the *weighted average* percentage for insurers which use exclusive agents; and if an insurer uses independent agents, the filer shall use the *weighted average* percentage for insurers which use independent agents. *Countrywide net written premiums for private passenger automobile liability and physical damage lines of business shall be used as the weights.*

RESPONSE: As noted above, the Department has determined that the expense provision for insurers should be calculated on weighted averages. This clarification has been incorporated into the amendment.

The Department agrees with the commenter's observation that start-up costs for new companies may distort the averages. As a result, the Department has determined that any new companies, with one year or less experience, will be eliminated from the list of top 20 insurers. This does not affect the rule as proposed. Former names of companies have been included in the Exhibit, where appropriate, for the convenience of filers.

The Department has also clarified in the amendment that insurers should be limited to using only the companies listed in Exhibit H and all insurers from the appropriate category must be considered in the expense calculation.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions to proposal in brackets with asterisks *[thus]*):

11:3-16.10 Rate calculation using standard ratemaking methodology

(a) (No change.)

(b) Underwriting expense provisions shall be determined as follows:

1.-5. (No change.)

6. In determining the historic expense provision for commission and brokerage, other acquisition expenses and general expenses on a combined basis, the percentage to premium for each year of experience shall be limited to a maximum of the *[percentage]*

weighted average of the percentages shown in "Best's Aggregates and Averages" for the same period for ***those*** property/casualty insurance companies which most closely approximate the insurer's method of marketing automobile insurance as set forth in Exhibit H to the Appendix, incorporated herein by reference.

i. If an insurer uses salaried employees which deal directly with the public, the filer shall use the ***weighted average*** percentage for insurers which use salaried employees which deal directly with the public; if an insurer uses exclusive agents, the filer shall use the ***weighted average*** percentage for insurers which use exclusive agents; and if an insurer uses independent agents, the filer shall use the ***weighted average*** percentage for insurers which use independent agents.

ii. For the purposes of this section, the calculation of the weighted average shall be based upon written premiums in New Jersey in the year prior to making the filing.

7.-10. (No change.)

(c)-(f) (No change.)

APPENDIX
EXHIBIT H

Marketing Methods for the
Top 20 Private Passenger Auto Insurers in New Jersey

Independent Agents:

Aetna Casualty and Surety Co.
Atlantic Employers Insurance Co.
Camden Fire Insurance Association
Continental Insurance Co. of New Jersey
Hanover Insurance Co.
Harleysville Garden State Insurance Co.
Liberty Insurance Corp.
Newark Insurance Co.
Ohio Casualty Insurance Co.
Parkway Insurance Co.
Selective Insurance Co.
Twin City Fire Insurance Co.
United States Fidelity & Guaranty Co.

Captive Agents:

Allstate Insurance Co.
Keystone Insurance Co. of New Jersey
(formerly Keystone Insurance Co.)
Prudential Property and Casualty Insurance Co. of NJ
State Farm Mutual Auto Insurance Co.

Direct Writers:

Liberty Mutual Fire Insurance Co.
New Jersey Manufacturers Insurance Co.
United Services Auto Association

(a)

DIVISION OF LIFE/HEALTH ACTUARIAL

Selective Contracting Arrangements of Insurers Adopted New Rules: N.J.A.C. 11:4-37

Proposed: October 4, 1993 at 25 N.J.R. 4554(b).

Adopted: December 22, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Filed: December 22, 1993 as R.1994 d.45, **with substantive and technical changes** not requiring additional public comment (See N.J.A.C. 1:30-4.3).

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.

Effective Date: January 18, 1994.

Expiration Date: November 30, 1995.

Summary of Public Comments and Agency Responses:

The Department received a total of 2,318 timely comments on the proposed new rules. Of those commenting, 1,802 did so by way of a form letter (see last Comment and Response below); a list of such commenters may be inspected at the Department or the Office of Administrative Law. Other commenters were as follows:

Comments Received from Insurance Industry; State Offices; Medical Associations and/or Societies on N.J.A.C. 11:4-37

Ellen Kiehl, (PIA)
David Mannis, (CIGNA)
Karen Cwirka, (MassMutual)
Gavin Blair, (Liberty Mutual)
Kay McCormick, (Law & Pub. Safety—State Brd. of Med. Exams.)
Joseph Doria, (Assem. Dem. Office)
Michael Kaplan, (BC/BS of N.J.)
Irving Tecker, (N.J. Podiatric Med. Soc.)
Lu Ann M. Guerriero, (Monmouth-Ocean County Chiro. Soc.)
David F. Grimm, (N.J. Optometric Association)
Barbara A. Levy, (Aetna Insurance Co.)
James O'Connor, (The Prudential)
Martha Roberts Nolan, (MetLife)
Phillip Cocuzza, (N.J. Dental Association)

General Comments Received on 11:4-37

Joan Smedley
John J. Carollton
Raymond Seugling
Steven F. Carrollton
Barbara Rickert
Dr. Wayne M. Poller
Brian Atkisson, D.C.
Timothy J. Eustace, D.C
Dr. Charles S. Berg
Albert R. Widmer, D.C.
Duane George
Teresa Kit-Yu Ngo, D.C.
George Kay-Chee Ngo, D.C.
Joseph K. Doyle, D.C.
Wendy B. Taylor, D.C.
William A. Taylor
Philip H. Boos, D.C.
Dr. Edward J. Sarubbi
Margaret Ginter
Inez Westerhoek
Marc P. Schneider, D.C.
John DeLuca, D.C.
Dr. Lawrence S. Altman
Karen A. Robinson, D.C., P.A.
Vincent Spinazzola, D.C.
Michael W. Goione, D.C.
G. Jay Van Seters, D.C.
Glenn S. Eigenmann, D.C.
Dr. Robert Warsak
Rosann M. Taylor
Catherine B. Kelly, D.C.
Dr. Charles T. Waldron
Linda M. Drozd
Frederick R. Santangelo, D.C.
Joseph J. Garolis, DC
Dr. R.W. Altschuler, D.C.
Dr. James Tighue
Dr. Karl Natriello
Dr. Joseph Intellisano
Gerald Lowder
Thomas G. D'Elia, D.C. (Belleville Chiro. Center)
Mark V. Russo, D.C., F.I.C.C. (Northern N.J. Chiro. Soc. Legislative Committee)
Douglas Levine, D.C. (Chiropractic Healthcare)
Dr. Charles Paolino, P.A.
Robert Kovacs, D.C. (Kovacs Chiro. Office)
Lisa Capanna Kovacs, D.C. (Kovacs Chiro. Office)
Richard Santucci (Bergen Family Chiro. Office)
Robert S. Gold, Esq.
Dr. Joseph Musso

Dr. Michael Schill (Elmwood Park Chiro.)
Dr. Daniel Golden
Dr. Robert Bado
Dr. Gene Wentzel
David Plaut (NFL Films)
Dr. Michael J. Lieberman (Woodbury Family Chiro.)
Dr. Thomas G. Conte (West Trenton Chiro. Center)
Dr. Robert Weissman
Dr. Stanley Pilton (White Horse Chiro. Center)
Eileen Stoudt
Dr. Alan B. Levine
Dr. Ronald Levine (Princeton Chiro. Center)
Dr. Mark C. Zientak (Back and Neck Care Center)
F. Cleary
Linda Goerina
E. Robinson
Catherine Kaplan
Linda Los
Dr. Seth M. Rossinow
Maryann Powell
Dr. Steven Clarke
Richard Bonkowski
Dr. Joseph F. Bednar
Dr. Paul Blank
Dr. Peter N. Boulukos
Evelyn Galar
Nicolette Barbara
Diego Gonzalez
Richard E. Glass, D.C.
William R. Wallace, D.C.
Dr. Juan C. Grana (Madison Chiropractic Center)
Dr. Robert L. Sylvester, D.C. (Sylvester Chiro. Centre)
Dr. John R. Winn, D.C.
Dr. Michael J. Cooney, D.C., P.A.
Jill S. Sauro (Advanced Physical Therapy)
Dr. Robert Levine, D.C.
Dr. Philip T. Santiago (Santiago Chiro. Assoc.)
Dr. Edward Catalano (Santiago Chiro. Assoc.)
Kim A. Sommer, D.C.
Patrick R. Smith, D.C.
Anthony Turco
Harvey Jones
Dr. Lisa Cianciulli, B.S., D.C.
Dr. E. P. Cianciulli, D.C., M.S., F.I.C.C.
Dr. Glen C. Cianciulli, D.C.
Dr. Anthony P. Amato
Dr. Ciro F. Scilingo
Dr. Charles S. Corallo
Dr. Thomas A. Senatore
Dr. James Cuozzo
Gary Yancius, D.C.
Richard B. Taylor, D.C.
Isabella Daubert
John D. Fanburg & Todd C. Brower (Brach, Eichler, Rosenberg, Silver, Bernstein, Hammer & Gladstone)
Dr. Joseph C. DeFazio, D.C.
Dr. Alexander DiMeo
Dr. William P. Dorney, D.C.
Dr. Louis Stimmel
Dr. Michael Fedorczyk
Dr. Kevin Emery
Mary Ann Leone
Nicholas Leone
Jennifer Melchect
Robert Voorhees
Patricia J. Cappello
Robert Moat, D.C.
Howard Prager, D.C.
Dr. John T. Ford
Mel W. Tantillo, D.C.
Richard Beekman, D.C.
Leonard M. Russo, D.C.
Robert A. Kramer, D.C.
Dr. John F. Cerutti
Dr. Barry Lichtenstien
Scott Kloorfain, D.C. & Michael Kloorfain, D.C.
Dr. David Haldey

COMMENT: One commenter suggested that at proposed N.J.A.C. 11:4-37.3(b)1iv, the word "service" be added to read "geographic service area."

RESPONSE: Proposed N.J.A.C. 11:4-37.3 had been deleted in its entirety, but the word "service" has been added to a similar provision at adopted N.J.A.C. 11:4-37.4(c)3 and 8.

COMMENT: One commenter suggested revising the definition of "health care provider" by adding the words "or certification by the Department of Health" after "within the scope of its licensure."

RESPONSE: The Department has added the suggested language to improve accuracy.

COMMENT: One commenter suggested revising the proposed definition of "allowable expense" ("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") to include a minimum standard for usual, customary and reasonable. The commenter added that a Milliman & Robertson report submitted to the National Association of Insurance Commissioners (NAIC) recommended that regulations be developed requiring carriers to disclose certain information concerning their usual, customary and reasonable (UCR) calculations and set minimum standards. The commenter further stated that without a standard UCR calculation formula, consumers will be unable to compare premium rates of competing plans since the allowed expense may differ greatly from plan to plan.

RESPONSE: UCR has been defined by both the Small Employer Health Benefits Program Board of Directors (SEH Board) and the Individual Health Coverage Program Board of Directors (IHC Board) for standard health benefits plans specifically for purposes of meaningful comparison of those plans. However, it is the Department's position that it is inappropriate for the Department to provide a minimum standard for UCR regarding non-standard plans because currently in New Jersey no minimum standard exists. Each insurer makes its own determination as to what constitutes UCR based on its own sources or database.

COMMENT: One commenter suggested adding the following at proposed N.J.A.C. 11:4-37.4(a)2 regarding adequate numbers of providers by specialty in the standards for selective contracting arrangements: "This shall include a narrative description of the applicant's criteria for determining the adequate number of providers and why these criteria were chosen and determined to be appropriate. These criteria shall be based on appropriate references in the managed care literature and/or the current experience of the applicant. These criteria shall be submitted as part of the selective contracting arrangement approval application. The service network must be consistent with N.J.A.C. 8:38-1.4(a)4 and prevailing industry standards."

RESPONSE: N.J.A.C. 11:4-37.4 merely sets forth the standards to be met by a carrier applying for approval of its selective contracting arrangement. The carrier's approval application is the appropriate place to include information regarding the manner in which the standards will be met. The Department of Health has established standards used in evaluating the adequacy of HMO provider networks, which are based on the demographics of the HMO's potential pool of covered persons. The Department of Health intends to use its discretionary authority by cooperating with carriers for purposes of evaluating the adequacy of the preferred provider pool of a particular selective contracting arrangement seeking approval under these rules. Accordingly, the commenter's suggested change is unnecessary.

COMMENT: Two commenters requested that the rules include a definition of "medical specialty." The commenters questioned whether a specialty would be considered "foot care," or the relevant specialists be podiatrists and orthopedists; is the specialty "vision care," or are the specialists optometrists and ophthalmologists? One of the commenters stated that this distinction becomes particularly important if the Department intends to retain the phrase "or class" at N.J.A.C. 11:4-37.4(a)10 (permitting selective contracting arrangements to limit the number or classes of preferred providers), in which case the question arises as to whether the Department intends for "specialty" and "class" to mean the same and be interchangeable.

One commenter suggested that the rules include language at N.J.A.C. 11:4-37.4, which sets forth the standards for selective contracting arrangements, requiring PPOs to utilize the services of competing providers. For example, whenever basic eye care services or supplemental vision care services are offered through the selective contracting arrangement,

such services shall be provided by both licensed optometrists and board certified ophthalmologists, and that the arrangement shall include sufficient licensed optometrists to assure that the covered person can choose to have the services provided by an optometrist unless the service to be provided is outside the scope of practice of an optometrist.

The commenter also recommended that N.J.A.C. 11:4-37.4(a)1 include language requiring same specialty utilization review.

RESPONSE: The Department believes it is unnecessary to include a definition of "medical specialty" in the rules because the provider community at large has an understanding of the meaning of that term, and the scope of that term may change consistent with changes in medical technology. Moreover, the Department possesses no authority to direct carriers concerning their preferred provider network. Nevertheless, the indemnity contracts of all carriers are required to be in compliance with New Jersey law concerning reimbursement of providers (that is, any type of health care provider may perform services that are within the scope of the provider's licensure and the carrier is required to make payment for the services). Furthermore, if a carrier intends to seek approval of an existing HMO network as a selective contracting arrangement, the carrier will be required to expand the HMO network in order to comply with those laws.

Regarding the comment concerning same specialty utilization review, the utilization review process generally is undergoing review at both the Federal and State levels. New Jersey's Departments of Health and Insurance are reviewing that process. Accordingly, the Department believes that it would be premature at this time to include specific utilization review criteria in these rules.

COMMENT: One comment concerned the rules' proposed definition of "carrier." The commenter questioned whether the Department intends to continue its practice of exempting out-of-State group contracts from the provisions of New Jersey law, or whether the Department intends for all group contracts which provide coverage to New Jersey residents to be covered by these rules and the other provisions of Title 17.

RESPONSE: The Department is revising N.J.A.C. 11:4-37.1(b) to indicate that these rules apply to all carriers operating pursuant to Title 17B of the New Jersey statutes, and issuing health benefits plans in this State or which cover New Jersey residents. This revised language clarifies the Department's intended meaning.

COMMENT: One commenter suggested revising proposed N.J.A.C. 11:4-37.5(b)10 and 11, which set forth the contents of the application for approval, as follows (suggested addition in boldface **thus**):

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.

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.

iv. a description of the staff and their qualifications that will be responsible for the quality assurance program.

RESPONSE: The Department is revising proposed N.J.A.C. 11:4-37.5(b)10 and 11 to conform to the commenter's suggested language, which more accurately describes certain items to be included in carrier's approval application.

COMMENT: One commenter suggested adding language to proposed N.J.A.C. 11:4-37.5(d), which sets forth the Department's procedures for review of approval applications, to the effect that a carrier whose selective contracting arrangement is denied approval has the right to request an administrative hearing as provided in proposed N.J.A.C. 11:4-37.7(c).

Another commenter stated that a notice and hearing requirement should be added providing notice to participating providers whose contractual relationship has been terminated by either a PPO or carrier. The commenter suggests adding language to both the PPO registration requirements section at N.J.A.C. 11:4-37.3 and to the standards for selective contracting arrangements subsection at N.J.A.C. 11:4-37.4(a). The commenter suggested that the following language be added to the standards subsection: "The selective contracting arrangement shall include a procedure to be followed when a relationship with a participating provider is to be terminated; such procedure shall include, at a minimum, adequate written notice to the participating provider and an opportunity for that provider to appeal the termination."

RESPONSE: The Department agrees with the first commenter's suggested language, and has revised N.J.A.C. 11:4-37.5(d) accordingly. Regarding the second comment, the individual contract between either the carrier and PPO or the PPO and its participating providers, rather than the selective contracting arrangement, would more appropriately include language concerning the rights of providers in the event their contract for services has been terminated.

COMMENT: One commenter stated that the definition of "emergency care" describes out-of-network emergency care which is required to be covered at the preferred rate, rather than providing a general definition. The commenter suggested that the definition be clarified to treat the two issues separately.

RESPONSE: The Department believes that the proposed definition of "emergency care" adequately describes those situations where, under the selective contracting arrangement, a carrier would be responsible for payment of the medical services provided.

COMMENT: One commenter expressed its concern with the rule's requirement that emergency services be covered as if the covered person had been treated by a preferred provider rather than at some stated contractual level. The commenter added that this requirement could lead to misuse of the emergency services exception.

RESPONSE: The Department disagrees. The emergency services exception necessarily requires that an emergency situation exist. If the carrier determines that an emergency situation does not exist based on the rules' definition of "emergency care," payment should be made at a decreased rate.

COMMENT: One commenter stated that it assumed that by defining a "covered service," the Department intended to allow a selective contracting arrangement for a single health care service (for example, dental, mental health coverage). If that is the case, the commenter added that certain standards contained in the rules appear to be unreasonable for such plans and would require modification. The commenter, however, failed to identify which standards it believed to be unreasonable.

In a related comment, the commenter stated that the proposed rules do not appear to include a requirement that a network desiring to register with the Department provide the full range of health care benefits or that a carrier can only contract with a network that provides the full range of health care benefits covered by the carrier. The commenter questions (1) whether a carrier will be permitted to contract with multiple networks (that is, carve out portions of the benefits package to different networks); (2) whether a carrier can utilize different networks for each of the state mandated policies; and (3) whether a medical specialty (for example, cardiologists or neurosurgeons) can form a registered PPO to deliver medical specialty services to a carrier on a statewide basis.

A third commenter stated that the proposed rules seem not to exclude the possibility that a Point of Service (POS) arrangement could obtain the Commissioner's approval as a selective contracting arrangement. The commenter recommended that the rules include explicit authorization for such arrangements.

RESPONSE: It is the Department's intention not to exclude single service selective contracting arrangements, and a group of medical providers in one specialty may form a PPO. Further, carriers may contract with multiple networks of providers in order to provide a number of different services. The commenter's question concerning a carrier being permitted to utilize different networks for each of the State mandated policies is unclear. Finally, the Department does not necessarily intend to exclude a Point of Service (POS) arrangement from being approved as a selective contracting arrangement provided the POS is a PPO with a gatekeeper, rather than an HMO POS.

COMMENT: One commenter suggested that the rules include a definition of "copayment" since a definition of "coinsurance" is provided. The commenter suggested that "copayment" should mean a fixed dollar payment made by the covered person which is collected by the provider at the time the services are delivered.

RESPONSE: The Department agrees that the rules should include a definition of "copayment," and has included such a definition which is consistent with N.J.A.C. 11:21, the rules implementing the Small Employer Health Benefits Program Act.

COMMENT: One commenter stated that proposed N.J.A.C. 11:4-37.4(a)6 is confusing and should be clarified. According to the commenter, the language in that provision requiring the carrier, within

30 days of entering into a selective contracting arrangement, to provide covered persons with evidence of coverage, appears to say that covered persons must be provided with evidence of coverage whenever the carrier contracts with a provider. The commenter's reasoning is that the rules define "selective contracting arrangement" as an arrangement between health care providers and either carriers or preferred provider organizations.

RESPONSE: The Department has revised the language at proposed N.J.A.C. 11:4-37.4(a)6 to clarify its intended meaning.

COMMENT: One commenter stated that the proposed definition of "preferred provider organization" or "PPO" is overly broad and includes certain health care providers that should be exempt (for example, physician entities engaged in selective contracting arrangements, which have contractual relationships with their members/shareholders regarding the provision of services and remuneration therefor). The commenter suggested amending the definition to specifically exclude not only a carrier contracting with health care providers, but also a health care provider. In a related comment, the commenter questions whether or not a network of vision care providers (that is, optometrists and ophthalmologists) offering basic and/or supplemental vision care services to carriers would be required to register as a "preferred provider organization." The commenter assumes that such a network would be required to register if it wished to contract with a covered carrier, but further questions whether the network would be required to register if it offered only supplemental vision care services (routine annual eye exams and an eyeglass benefit) through a "vision care rider" on a policy.

RESPONSE: The Department is revising the definitions of both "preferred provider organization" and "selective contracting arrangement" to clarify their intended meanings.

Regarding the second comment, the Department has deleted in its entirety the PPO registration provision proposed at N.J.A.C. 11:4-37.3.

COMMENT: Several of the comments received concerned the rules' proposed PPO registration provision (N.J.A.C. 11:4-37.3). (1) A few of the commenters stated that by requiring PPOs to register, the Department exceeds its statutory authority. (2) The information the Department is seeking from the PPOs can more appropriately be obtained from carriers contracting with PPOs in order to establish selective contracting arrangements. (3) Since the carriers assume the risk in these arrangements, they should bear the responsibility of choosing an appropriate PPO. (4) The PPO registration provision contains no standards by which PPOs could be rejected by the Department. (5) The requirement that PPOs provide the Department with an audited financial statement is arbitrary and capricious and imposes an irrational and unreasonable burden on PPOs in that it would be very expensive for a privately-owned PPO to obtain an audited financial statement, and the only purpose for such a document would be compliance with these rules. (6) One commenter questioned whether the proposed PPO registration provisions are not applicable to carriers contracting directly with preferred providers and whether it is clear that PPOs can act only in conjunction with a carrier. (7) Another commenter stated that N.J.A.C. 11:4-37.3(a) should be amended to clarify that carriers contracting with preferred providers through an affiliated entity need only register with the Department by following the procedures at N.J.A.C. 11:4-37.5. (8) The same commenter questioned whether Individual Practice Associations (IPAs) providing basic and supplemental services only to licensed HMOs need to register as a PPO, or will the registration requirement kick in only if the IPA also has or contemplates having a contract with a carrier; and whether third party administrators that administer panels for ERISA-qualified plans or for multi-employer arrangements are also required to register.

RESPONSE: The Department disagrees that it exceeded its statutory authority in any manner since the Department's proposed rules did not require that PPOs register with the Department, but rather indicated that PPOs seeking to contract with a carrier in order to establish a selective contracting arrangement may register with the Department. However, under the proposed rules carriers could only contract with registered PPOs. Nevertheless, the Department agrees with the comment that the Department can obtain the PPO information it is seeking from the carriers applying for approval of their selective contracting arrangements. Accordingly, the Department is deleting N.J.A.C. 11:4-37.3 in its entirety, and revising the section setting forth the selective contracting arrangement approval procedures to include certain items that were contained in the proposed PPO registration section. Moreover, the Department has deleted the requirement that the PPO provide an audited financial statement.

Finally, the Department has added language at proposed N.J.A.C. 11:4-37.5(a) similar to that which appeared at proposed N.J.A.C. 11:4-37.3(a) indicating that no carrier may issue a health benefits plan utilizing a selective contracting arrangement unless the carrier has entered into the selective contracting arrangement either directly with preferred providers or has contracted with a preferred provider organization.

COMMENT: The Department received four comments on the coinsurance differential provision at proposed N.J.A.C. 11:4-37.4(a)9. One commenter stated that it supports the 30 percent differential, and urges that at least that percentage level remain in any final rule adopted by the Department. Another commenter stated that including deductibles and copayments complicates the calculation of the differential, and the term "equivalent" used in that provision could impede the ability to incent in-network usage. The commenter suggests that if the Department's concern is that certain deductible levels might make the out-network benefit illusory, the Department could apply a reasonable standard in judging the application of such out-network deductibles and/or copayments by revising the language as follows: "The in-network and out-network benefit level differential shall not exceed 30 percent, excluding any reasonable deductibles and copayments." A third commenter stated that the differential should be increased to 40 percent as an effective incentive to seek in-network care, and that the use of a statutory maximum differential for in- and out-network care explicitly not prohibit the application of a different deductible for out-network care. Finally, a fourth commenter recommended that the rules eliminate the reference to copays and deductibles and cite only a coinsurance differential because their inclusion is impractical and problematic. The commenter added that if the Department's concern is about deductibles and copays on the out-of-network services, the Department could include provisions relating to the reasonableness of those deductibles and copays without affecting the coinsurance differential.

RESPONSE: As the Department previously stated in the rules' proposal Summary published in the October 4, 1993 edition of the New Jersey Register (25 N.J.R. 4554(b)), the maximum 30 percent coinsurance differential is reasonable in light of differentials currently utilized by the industry and in order to promote health care cost containment while adequately preserving quality of care. A larger differential may begin to adversely affect quality of care, while a significantly smaller maximum differential may not be sufficient to encourage cost containment. Moreover, the maximum 30 percent coinsurance differential is consistent with that adopted by both the Individual Health Coverage Program (IHC) Board and Small Employer Health Benefits Program (SEH) Board for their standard health benefits plans. Accordingly, it is the Department's position that a revision of the maximum 30 percent coinsurance differential is unnecessary.

COMMENT: One commenter stated that the requirement at proposed N.J.A.C. 11:4-37.4(b)iii that carriers with selective contracting arrangements filed and approved by the Commissioner and in effect prior to June 1, 1993 are to file a Plan of Compliance by January 1, 1994, is unnecessary. Rather, the commenter suggested that the Plan of Compliance should be filed 30 days prior to the January 1, 1995 compliance deadline. Another commenter suggested that the rules permit a carrier using its licensed HMO network as its selective contracting arrangement network to have two more years in which to comply with the rules' requirements.

RESPONSE: In light of the fact that a January 1, 1994 deadline for carriers to file their Plans of Compliance appears to be unrealistic, the Department is revising proposed N.J.A.C. 11:4-37.4(b)iii (recodified as N.J.A.C. 11:4-37.4(b)3) to require that carriers file their Plans of Compliance within 90 days of the effective date of these rules. The Department has additionally changed the January 1, 1995 compliance deadline to within 15 months following the rules' effective date. It is the Department's position that all carriers, including a carrier utilizing its licensed HMO network as its selective contracting arrangement, are required to comply with that deadline for meeting the requirements of these rules.

COMMENT: One commenter stated that the proposed rules' approval procedures at N.J.A.C. 11:4-37.5 are not unduly burdensome, but that the rules should be clarified so as not to require a carrier to file a health benefits plan with the Department each time a "case" is sold to an employer using the selective contracting mechanism. Rather, the commenter suggested that, where practical, one contract form be filed indicating those areas of the contract that may be tailored to the needs of the particular employer.

RESPONSE: The commenter is apparently misreading the rules. The procedures set forth at proposed N.J.A.C. 11:4-37.5 do not require carriers to file with the Department a health benefits plan each time a case using a selective contracting mechanism is sold to an employer. Rather, proposed N.J.A.C. 11:4-37.5 requires only that a carrier file the various standard form contracts it intends to utilize, which shall include variable language that may be contained in the actual contract. The Department is revising proposed N.J.A.C. 11:4-37.5(b)6 and 13 to clarify the intended meaning.

COMMENT: A few commenters commented on the requirement at proposed N.J.A.C. 11:4-37.5(b)20 that carriers submit to the Department the business plan of the carrier's division responsible for managing selective contracting arrangements and of the PPO if appropriate. The comments indicated that such information is unnecessary in a regulatory filing, and is proprietary. The commenters further requested that the rules either clarify exactly what information the Department is seeking in a business plan or delete the requirement. One of the commenters stated that the rules should include a provision recognizing the confidentiality of these documents.

RESPONSE: The Department has revised proposed N.J.A.C. 11:4-37.5(b)20 to delete the business plan submission requirement and to more accurately describe the items which the Department is seeking under this provision, which it believes are both necessary and appropriate to be reviewed in connection with approving a selective contracting arrangement. Regarding the comment that the rules should recognize the confidentiality of the documents submitted, the rules contain a confidentiality provision at N.J.A.C. 11:4-37.5.

COMMENT: One commenter stated that proposed N.J.A.C. 11:4-37.7(a)5, which provides that a selective contracting arrangement's approval may be suspended or revoked if the Commissioner determines that the arrangement for the payment of covered services is contrary to the interests of covered persons or the public, is too broad. The commenter questioned what "arrangement" is referred to, and who determines what is "contrary to the interests of covered persons or the public." The commenter further stated that the provision includes no standards by which a carrier or PPO can determine the basis for a review or regulatory determination.

RESPONSE: The Department is deleting this provision from the rules as unnecessary because proposed N.J.A.C. 11:4-37.7(a)1 and 2 sufficiently cover the basis for suspension or revocation with which the Department was concerned in proposed paragraph (a)5.

COMMENT: A few comments concerned the filing and review fees set forth at proposed N.J.A.C. 11:4-37.9. One commenter stated that the $3,000 fee for filing the Plan of Compliance is as high as the selective contracting arrangement filing fee. Another commenter stated that it is punitive to charge carriers $3,000 every two years for filing their selective contracting arrangements. The commenter further stated that no other insurance license approval expires, and that the two-year expiration is unnecessary because of the requirement at proposed N.J.A.C. 11:4-37.5(c) that carriers report to the Department any significant changes in their selective contracting arrangements. Finally, one commenter requested a clarification that the $3,000 filing fee at proposed N.J.A.C. 11:4-37.9(b) refers to all three items in that subsection (the initial filing of selective contracting arrangements, the biennial renewal application and the Plan of Compliance).

RESPONSE: The Department disagrees with the comment that no other insurance license approval expires. Dental plan organizations (DPOs) currently require a $1,000 application fee, as well as an annual renewal fee. Although HMOs are required to pay an application fee, but no renewal fee, proposed legislation would require payment of a per-member assessment to cover administrative costs. In light of the fact that both the Department and the Department of Health are responsible for the review and approval of selective contracting arrangements and any subsequent revisions and changes, the fees established under these rules are both reasonable and appropriate.

The Department is modifying the approval renewal procedure slightly, however, by requiring only a triennial renewal instead of biennial. Moreover, renewal applications are to be filed no later than 60 days prior to the expiration date of the previous approval, and shall be deemed approved unless the Department issues a written notice of disapproval within 60 days of receipt of the application. The $3,000 fee will remain the same.

In response to the comment requesting a clarification of the filing fees set forth at proposed N.J.A.C. 11:4-37.9(b), each item included in that provision requires a separate filing fee of $3,000. That provision has been revised to clarify that intent.

COMMENT: One comment concerned the rules' confidentiality provision at proposed N.J.A.C. 11:4-37.6. The commenter stated that since the Department has no statutory authority to regulate PPOs, it is both inappropriate and an abuse of the Department's discretion to promulgate rules allowing the release of competitively sensitive data submitted by PPOs. The commenter stated that the proposed language at N.J.A.C. 11:4-37.6(a) is meaningless because it contains no substantive standards, and the Department has no discretion to decline to release to anyone any of the items in the confidentiality section for which it receives a request. The commenter further stated that it is unclear what a "specified" request is, and it is unclear whether the Department or the entity requesting the information is required to notify the entity submitting the information.

RESPONSE: The Department has revised the confidentiality provision to reflect the changes resulting from the deletion of the PPO Registration provision and the revision of proposed N.J.A.C. 11:4-37.5 to include certain items that were previously included in the proposed PPO Registration provision at N.J.A.C. 11:4-37.3. The items now listed under the confidentiality provision are to be submitted to the Department by carriers as part of their selective contracting arrangement approval application. The commenter is correct in stating that the Department has no discretion to decline to release to anyone any of the items listed in the confidentiality section for which it receives a request. Those listed items are not confidential, but are public records to which the public has access. The Department intends a "Specified" request to be one which specifically identifies the items requested. The Department has deleted the words "and upon notice to the entity submitting such information" in subsection (a) because such notice is overly burdensome to the Department, and is unnecessary in releasing public documents.

COMMENT: One commenter stated that the risk assumption provision at proposed N.J.A.C. 11:4-37.3(b)1vi requires clarification. The commenter suggested that the language indicating that the PPO does not assume risk in providing 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," should be revised to "with respect to a preferred provider arrangement." Another commenter questioned whether this provision would prohibit a registered PPO from accepting capitated contracts from a carrier wherein the members of the PPO were at some degree of financial risk if utilization exceeded the capitated payments to the network from the carrier. Another commenter asked whether a prepayment arrangement would be prohibited by this provision.

RESPONSE: The language previously appearing in proposed N.J.A.C. 11:4-37.3(b)1vi has been included at N.J.A.C. 11:4-37.4(c)2. The Department is unclear as to whether the first commenter's suggested language change sufficiently precludes the PPO from assuming risk as intended by the Department.

This provision is not intended to restrict a prepayment arrangement. Moreover, under these rules, capitation (that is, a fixed per-member per-month payment or percentage of premium payment to preferred providers, wherein the preferred provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided) is not necessarily precluded. However, in order to effectively distinguish between selective contracting arrangements and HMOs with point-of-service (POS) plans, the Department intends to propose amendments to these rules prohibiting capitation in the use of selective contracting arrangements to become effective 15 months after the effective date of these rules. This effective date is intended to coincide with the provision in these rules at N.J.A.C. 11:4-37.3(c) requiring full compliance by all selective contracting arrangements with the requirements of these rules.

COMMENT: The Department received over two thousand comments (many of which were form letters), mainly from chiropractors and chiropractic patients throughout the State, on proposed N.J.A.C. 11:4-37.4(a)10, permitting reasonable limits to be placed on the number or classes of preferred providers in selective contracting arrangements. The basic argument of all these comments is that by allowing carriers to selectively exclude entire classes of providers, the patient's freedom to choose the type of health care provider to treat them is limited. Some commenters stated that eliminating entire classes of providers is overtly anticompetitive and clearly violative of fundamental fairness. Some of the commenters argued that by statute where a policy provides for reimbursement for any service which is within the lawful scope of practice

of a duly licensed chiropractor, a person covered under such policy or the chiropractor rendering such service will be entitled to reimbursement. The commenters further state that any health insurance delivered in this State must include chiropractors if that service is being offered for any other health care providers. The commenters suggest replacing the proposed language with language to the effect that selective contracting arrangements may not discriminate on the basis of gender, ethnicity, religion or type of health care professional. Some of the comments suggested that the phrase "or classes" be deleted and only a limit on the number of providers be established. One commenter stated that N.J.A.C. 11:4-37.4(a)10 in its entirety is unnecessary since N.J.A.C. 11:4-37.4(a)2 already establishes the principle that carriers are only required to utilize an adequate number of providers by specialty, and that paragraph (a)2 cannot likely be construed to require a carrier to utilize all providers in a given specialty.

RESPONSE: The Department agrees with the comment that proposed N.J.A.C. 11:4-37.4(a)10 in its entirety is unnecessary, and has deleted that provision. Under the selective contracting arrangement, the carriers determine the level of benefits to be delivered, as well as the preferred provider network. The Department possesses no authority, statutory or otherwise, to direct carriers in their selection of the number or types of preferred providers. Indemnity carriers would be required statutorily to reimburse any type of provider who is providing a "covered service" under the selective contracting arrangement that is within the scope of the provider's licensure.

Summary of Changes Upon Adoption:

1. The second sentence of N.J.A.C. 11:4-37.1(a) has been deleted as unnecessary because of the deletion of proposed N.J.A.C. 11:4-37.3 in its entirety.

2. The word "authorized" in the first sentence of N.J.A.C. 11:4-37.1(b) has been changed to "operating," and the remainder of that sentence has been revised to clarify the Department's intended meaning. Additionally, the words "and to all preferred provider organizations entering into selective contracting arrangements with such carriers" have been deleted from the first sentence of N.J.A.C. 11:4-37.1(b) as unnecessary because of the deletion of proposed N.J.A.C. 11:4-37.3 in its entirety.

3. A definition of "copayment" has been added for clarification.

4. The definition of "health care provider" has been revised by adding the words "or certification by the Department of Health" for clarification.

5. The definition of "preferred provider organization" has been revised by replacing the words "health care" with "preferred" to clarify its intended meaning.

6. The definition of "selective contracting arrangement" has been revised to clarify its intended meaning.

7. Proposed N.J.A.C. 11:4-37.3, Registration of preferred provider organizations, has been deleted. Some of the items PPOs were requested to submit to the Department that were included in that provision have been included in N.J.A.C. 11:4-37.4.

8. N.J.A.C. 11:4-37.3(a)3, 6, 7, 8, 9 and 10 have been recodified, with the exception of (a)10, to a newly-created subsection at N.J.A.C. 11:4-37.3(b). Subsection (b) was created in order to more clearly differentiate between the standards applicable to a selective contracting arrangement set forth in subsection (a) and the criteria applicable to a health benefits plan utilizing a selective contracting arrangement now set forth in subsection (b).

9. The word "service" has been added at N.J.A.C. 11:4-37.3(a)2 for clarification.

10. Proposed N.J.A.C. 11:4-37.3(a)10 has been deleted as unnecessary.

11. N.J.A.C. 11:4-37.3(b) has been added to more clearly differentiate between these standards and those appearing at N.J.A.C. 11:4-37.3(a).

12. N.J.A.C. 11:4-37.3(b)1, setting forth a hold harmless provision for covered persons, has been added for consistency with the hold harmless provision appearing at N.J.A.C. 11:4-37.4(b)16.

13. N.J.A.C. 11:4-37.3(b)3 has been revised by replacing the words "entering into the selective contracting arrangement" with "delivering a health benefits plan utilizing a selective contracting arrangement" to clarify the intended meaning.

14. N.J.A.C. 11:4-37.3(b)4, 5 and 6 all previously appeared at N.J.A.C. 11:4-37.3(a). N.J.A.C. 11:4-37.3(b)4 and 5 have been revised slightly for clarification.

15. N.J.A.C. 11:4-37.3(b) has been changed to (c), and the codification of paragraphs (b)i through iv corrected to "(c)1 through 4."

16. N.J.A.C. 11:4-37.3(b)i (now (c)1) has been revised by changing the words "January 1, 1995" to "April 18, 1995" (that is, 15 months after the effective date of these rules) to permit an additional amount of time following the effective date of these rules for selective contracting arrangements to come into compliance with these rules.

17. N.J.A.C. 11:4-37.3(b)iii (now (c)3) has been revised to require carriers to submit a Plan of Compliance to the Department within 90 days of the rules' effective date, rather than by January 1, 1994 as proposed, since the proposed date appears to be unrealistic.

18. N.J.A.C. 11:4-37.4(a) has been revised by adding language previously included at proposed N.J.A.C. 11:4-37.3(a) stating that in order to issue health benefits plans utilizing selective contracting arrangements, carriers must either enter into such arrangements directly with preferred providers or contract with preferred provider organizations.

19. N.J.A.C. 11:4-37.4(a) has been recodified as subsection (b), and revised to clarify that carriers intending to make application to the Commissioner for approval of their selective contracting arrangements shall do so by using an approval application form to be provided by the Department, and by submitting the appropriate number of copies to the Department of Health.

20. N.J.A.C. 11:4-37.4(c)2 has added language previously included in proposed N.J.A.C. 11:4-37.3 requiring carriers contracting with PPOs to submit to the Department a certification from the PPO that the PPO neither engages in the business of insurance in this State nor assumes risk in the provision of its services on behalf of any person other than its own employees.

21. N.J.A.C. 11:4-37.4(c)3 has added the word "service" for clarification.

22. N.J.A.C. 11:4-37.4(c)5 has added language previously included in proposed N.J.A.C. 11:4-37.3 requiring a carrier to submit a description of its financial arrangements with the PPO if the carrier contracts directly with the PPO.

23. N.J.A.C. 11:4-37.4(c)6 has added the words "including variables" to clarify the Department's intent that only standard contract forms, including variables, are to be submitted by carriers to the Department for approval, rather than individual, actual contracts. The words "part of" in that same sentence have been changed to "utilized in" for clarification. Additional language has been added to this provision which previously was included in proposed N.J.A.C. 11:4-37.3 requiring carriers to submit to the Department the standard contract(s) or agreement(s) the carrier or PPO has entered into with the health care providers or classes of health care providers.

24. N.J.A.C. 11:4-37.4(c)8 has added the word "service" to clarify that carriers are to submit to the Department the geographic service areas of preferred providers.

25. N.J.A.C. 11:4-37.4(c)10 and 11 have been revised to more accurately describe certain items to be included in a carrier's approval application.

26. N.J.A.C. 11:4-37.4(c)13 has added the words "including variables" to clarify the Department's intent that only standard contract forms, including variables, are to be submitted by carriers to the Department for approval, rather than individual, actual contracts.

27. N.J.A.C. 11:4-37.4(c)13 and 14 have been revised by changing "N.J.A.C. 11:4-37.4(a)6" to "N.J.A.C. 11:4-37.3(b)3" to be consistent with the codification changes made.

28. In N.J.A.C. 11:4-37.4(c)16, the word "any" has been changed to "the" for clarification.

29. N.J.A.C. 11:4-37.4(c)20 has been added which includes language previously included in proposed N.J.A.C. 11:4-37.3 requiring carriers contracting with PPOs to submit to the Department a copy of the PPO's most recent finanial statement. However, the rule no longer requires that an audited financial statement be submitted.

30. N.J.A.C. 11:4-37.4(c)21 has been revised to more accurately describe the items the Department is seeking under this section.

31. N.J.A.C. 11:4-37.4(d) has been revised by deleting the words "together with the filing fee set forth at N.J.A.C. 11:4-37.9" as unnecessary because the filing fee has been eliminated.

32. N.J.A.C. 11:4-37.4(e) has been revised to include language permitting a carrier whose selective contracting arrangement has been denied approval to request a hearing pursuant to the procedures at N.J.A.C. 11:4-37.6.

33. N.J.A.C. 11:4-37.4(f) has been revised by changing the word "two" to "three" to indicate a three-year approval period.

34. N.J.A.C. 11:4-37.4(g) has been revised by changing the word "biennial" to "triennial" to indicate that approval renewal is required every

three years, and by adding language to clarify the approval renewal process.

35. At N.J.A.C. 11:4-37.5(a), the words "and upon notice to the entity submitting such information" have been deleted as both unnecessary and unduly burdensome to the Department.

36. At N.J.A.C. 11:4-37.5(a)2, the word "service" has been added for clarification.

37. At N.J.A.C. 11:4-37.5(a)4, the words "or PPO's" and "service" have been added for clarification.

38. In N.J.A.C. 11:4-37.5(a)10, the word "any" has been changed to "the" to conform to the same language change made in N.J.A.C. 11:4-37.4(b)16.

39. N.J.A.C. 11:4-37.5(a)11 (proposed N.J.A.C. 11:4-37.6(a)11) has been deleted as unnecessary.

40. In N.J.A.C. 11:4-37.5(a)11, the word "audited" has been deleted.

41. Proposed N.J.A.C. 11:4-37.5(a)13 has been deleted as duplicative of N.J.A.C. 11:4-37.5(a)4.

42. Proposed N.J.A.C. 11:4-37.5(a)14 has been deleted as unnecessary given the deletion of proposed N.J.A.C. 11:4-37.3.

43. N.J.A.C. 11:4-37.6 has been revised by adding the word "denial" to revise the section title to "Approval denial, suspension and revocation."

44. N.J.A.C. 11:4-37.6(a) has been revised by adding the word "denied" to reflect the inclusion in the section of approval denials.

45. N.J.A.C. 11:4-37.6(a)1 changed the words "no longer" to "not" to reflect the inclusion in the section of approval denials.

46. N.J.A.C. 11:4-37.6(a)5 has been deleted as unnecessary.

47. N.J.A.C. 11:4-37.8(a), setting forth the PPO registration fee, has been deleted as unnecessary because N.J.A.C. 11:4-37.3 has been deleted.

48. N.J.A.C. 11:4-37.8 has made various revisions to the rules' section numbers to reflect the change in numbering sequence throughout the rule resulting from deletion of the PPO registration provision.

49. N.J.A.C. 11:4-37.8(a) (proposed N.J.A.C. 11:4-37.8(b)) has been revised by adding the words "each of" to clarify that each item listed under that provision requires a separate $3,000 filing fee.

50. N.J.A.C. 11:4-37.8(a)3 has been revised by changing the word "biennial" to "triennial" referring to the triennial approval renewal application fee.

51. N.J.A.C. 11:4-37.8(b) has been revised by adding language to clarify the procedure for payment of certain fees.

52. Proposed N.J.A.C. 11:4-37.8(d) had been deleted as unnecessary.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

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. *[This subchapter further permits a preferred provider organization to register with the Department.]*

(b) This subchapter applies to all carriers *[authorized]* ***operating*** pursuant to Title 17B of the New Jersey statutes *[to issue]***, and issuing*** health benefits plans ***utilizing selective contracting arrangements*** in this State*[, and to all preferred provider organizations entering into selective contracting arrangements with such carriers]* ***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 *[health care]* ***preferred*** providers to establish selective contracting arrangements.

"Selective contracting arrangement" means an arrangement for the payment of *[benefits]* ***predetermined fees or reimbursement levels*** for covered services *[between health care]* ***by the carrier to preferred*** providers *[and either carriers]* or preferred provider organizations *[which establishes predetermined fee or reimbursement levels]*.

*[11:4-37.3 Registration of preferred provider organizations

(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 which have registered with the Department. Carriers intending to offer health benefits plans utilizing selective contracting arrangements shall follow the approval procedures set forth at N.J.A.C. 11:4-37.5.

(b) All PPOs may register with the Department by submitting three copies of the information specified below, together with the registration fee set forth at N.J.A.C. 11:4-37.9, at the following address:

ATTN: PPO Registration
New Jersey Department of Insurance
Managed Health Care Bureau
Division of Life/Health Actuarial Services
20 West State Street
CN 325
Trenton, NJ 08625-0325

1. The PPO shall include in the information submitted:

i. The official address and telephone number of the place of business of the PPO;

ii. A description of all of the activities in which the PPO engages;

iii. A copy of the PPO's most recent audited financial statement;

iv. A list of the names and addresses of preferred providers identified by specialty and geographic areas, and a copy of the provider directory to be distributed to covered persons;

v. A description of the standard contract(s) or agreement(s) the PPO has entered into with health care providers or classes of health care providers; and

vi. A certification signed by a senior officer 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.

2. If the information submitted is incomplete, the Department shall notify the PPO in writing of the deficiency, and shall provide the PPO with an opportunity to cure the deficiency within 90 days of the date of notice of the deficiency.

i. Any deficiency in the information required under this subsection shall prevent the PPO from being included among the Department's list of registered PPOs.

ii. Failure to cure a deficiency within the 90 day period will result in the requirement that the PPO resubmit its registration information in full, together with resubmission of the registration fee set forth at N.J.A.C. 11:4-37.9.

iii. Failure to be included on the Department's list of registered PPOs shall not entitle the PPO to the return of any portion of the registration fee.

(c) A PPO may apply for biennial renewal of its registration by updating the information previously submitted to the Department under this section. Renewal registration shall be subject to the filing fee set forth at N.J.A.C. 11:4-37.9(a).]*

11:4-*[37.4]***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. 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;]

*[4.]***3.*** The selective contracting arrangement shall include a procedure for resolving complaints and grievances of covered persons;

*[5.]***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;

*[6.]***3.*** The carrier shall, within 30 days of *[entering into the selective contracting arrangement]* ***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;

*[7.]***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;

*[8.]***5.*** The carrier utilizing a selective contracting arrangement *[for a]* ***may provide in its*** health benefits plan *[may provide]* 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;

*[9.]***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*[; and

10. The carrier may establish or enter into selective contracting arrangements which place reasonable limits on the number or classes of preferred providers]*.

*[(b)]***(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.

*[i.]***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 *[January 1, 1995]* ***April 18, 1995***.

*[ii.]***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.

*[iii.]***3.*** Every carrier with selective contracting arrangements subject to this subsection shall submit to the Department *[on or before January 1, 1994]* ***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.

*[iv.]***4.*** Carriers shall submit five copies of the Plan of Compliance described in *[(b)iii]* ***(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-*[37.5]***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.

*[(a)]***(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 *[to the Department]* 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]* ***the*** entire application, together with the ***appropriate*** filing fee set forth at N.J.A.C. 11:4-*[37.9]* ***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*

*[(b)]***(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*[, and]*****;*** 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*** area***s*** 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 *[part of]* ***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-*[37.4(a)6]***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-*[37.4(a)6]***37.3(b)3***;

15. A description of the incentives for covered persons to use the services of preferred providers;

16. A description of *[any]* ***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; *[and]*

20. A copy of the PPO's most recent financial statement if the carrier is contracting with a PPO; and*

*[20.]***21.*** The *[business plan of the carrier's division responsible for managing selective contracting arrangements and of the PPO if appropriate.]* ***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.*

*[(c)]***(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, *[together with the filing fee set forth at N.J.A.C. 11:4-37.9,]* 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

*[(d)]***(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.***

*[(e)]***(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 *[two]* ***three*** years excepting suspension or revocation pursuant to this subchapter.

*[(f)]***(g)*** A carrier shall apply for *[biennial]* ***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-*[37.8]***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-*[37.6]***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 *[and upon notice to the entity submitting such information]*:

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 *[any]* ***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 description of all the activities in which it engages;]

*[12.]***11.*** The PPO's most recent *[audited]* financial statement;

*[13. The names and addresses of the PPO's preferred providers by specialty and geographic areas, and the PPO's provider directory;

14. The PPO's description of the standard contracts or agreements it has entered into with health care providers or classes of health care providers;]*

*[15.]***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;

*[16.]***13.*** The carrier's or PPO's organizational chart;

*[17.]***14.*** The carrier's or PPO's listing and biography of its officers and directors;

*[18.]***15.*** The address of the carrier's or PPO's place of business; and

*[19.]***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-*[37.7]***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 *[no longer]* ***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*[; or]*

[5. The arrangement for the payment of covered services is contrary to the interests of covered persons or the public].

(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-*[37.8]***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-*[37.9]***37.8*** Filing and review fees

[(a) Every PPO registering with the Department pursuant to N.J.A.C. 11:4-37.3(b) shall pay a registration fee of $150.00 payable to "Treasurer, State of New Jersey."]

*[(b)]***(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-*[37.5]***37.4***;

2. A plan of Compliance pursuant to N.J.A.C. 11:4-*[37.4(b)]* ***37.3(b)***;

3. A *[biennial]* ***triennial*** renewal application of a selective contracting arrangement pursuant to N.J.A.C. 11:4-*[37.5(e)]* ***37.4(g)***.

*[(c)]***(b)*** The approval application***, renewal application and Plan of Compliance*** fee***s*** 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."

[(d) Every carrier filing with the Department any significant changes to its approved selective contracting arrangement pursuant to N.J.A.C. 11:4-37.5(c) shall pay a filing fee of $100.00 payable to "Treasurer, State of New Jersey."]

*[(e)]***(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.

(a)

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program Board Plan of Operation

Adopted New Rules: N.J.A.C. 11:21-2

Proposed: September 3, 1993 in accordance with P.L.1993, c.162, Section 16, at 25 N.J.R. 4563(a).

Adopted: December 15, 1993 in accordance with P.L.1993, c.162, Section 16 by the New Jersey Small Employer Health Benefits Program Board, Maureen Lopes, Chair.

Filed: December 22, 1993 as R.1994 d.48, **with substantive and technical changes** not requiring additional public notice or comments (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17B:27D-30, as amended by P.L.1993, c.162, Section 16.

Effective Date: December 22, 1993.

Expiration Date: October 15, 1998.

These new rules were proposed and are being adopted pursuant to the procedures set forth at P.L. 1993, c.162, Section 16, as therein authorized.

Accordingly, notice of the proposal of these new rules was sent for publication in three newspapers of general circulation in New Jersey, mailed to all known interested parties, and submitted to the Office of Administrative Law (OAL) for publication in the New Jersey Register.

Pursuant to P.L. 1993, c.162, Section 16, interested parties were provided a comment period of at least 15 days. As set forth in the notice of proposed new rules, the comment period ended on October 19, 1993. The Small Employer Health Benefits Program Board submitted the rules, which establish the Boards Plan of Operation, to the Commissioner of Insurance for approval in compliance with the requirements of N.J.S.A. 17B:27A-30. Pursuant to N.J.S.A. 17B:27A-30 a public hearing on the rules was held by the Department of Insurance, conducted by a Hearing Officer designated by the Department, on October 21, 1993. No recommendations were made by the Hearing Officer. A copy of the transcript of the proceeding can be obtained by interested parties by contacting Verice Mason, Assistant Commissioner, Legislative and Regulatory Affairs, Department of Insurance, CN 325, Trenton, New Jersey 08625. On December 3, 1994, the Department of Insurance approved the Plan of Operation, with certain technical changes to the following sections of N.J.A.C. 11:21-2: N.J.A.C. 11:21-2.1(e), 2.2, 2.8(c)2, 2.8(c)3, 2.11, 2.9(c)7, 2.9(e), 2.9(m), 2.10, 2.11, 2.12(b)6, 2.12(b)8, 2.14(e), 2.15(b), 2.16(a) and 2.16(b). These technical changes were approved by the Board on December 15, 1993, and are incorporated in the "Summary of Agency-Initiated Changes" below.

Written comments were received by the Board. Not all comments received were responsive to the proposed rules. The Board has responded only to those comments specifically relevant to the proposal.

Summary of Public Comment and Agency Responses:

The Small Employer Health Benefits Program received timely comments from the following:

Massachusetts Mutual Life Insurance Company

Medical Society of New Jersey

COMMENT: One commenter suggested the proposed regulations concerning the Plan of Operation be revised to include, among the members of the Board, a physician licensed to practice medicine in New Jersey, or a representative of an association of physicians.

RESPONSE: The make-up of the Board is set forth at N.J.S.A. 17B:27A-29 to include representatives of two small employers, seven carriers and the Commissioners of the Departments of Insurance and Health. The plan of operation, at N.J.A.C. 11:21-2.1(e), merely reflects the statute. No change to the rules in this regard is appropriate.

COMMENT: One commenter suggested that wording at N.J.A.C. 11:21-2.8(c)(4) be changed from "in favor" to "against" when discussing the resolution of assessment disputes.

RESPONSE: N.J.A.C. 11:21-2.8(c)(4) outlines the process the Board will follow in reallocating assessment amounts when an amount previously assessed is deferred by the Commissioner at a carrier's request, or when a carrier has successfully disputed an assessment amount. (The

commenter appears to be confusing the purpose of N.J.A.C. 11:21-2.8(c)4 with the purpose of N.J.A.C. 11:21-2.8(d)2.) The suggested change would not make sense, and is not being made.

COMMENT: One commenter asked how the committee will assess the reasons for a carrier's disproportionately low share of high risk groups, and whether carriers will have input to this process.

RESPONSE: The Board has not yet determined all of the criteria and standards it will use to evaluate a carrier's share of high risk groups, or the remediation for failure to have some share of high risk groups. The Board is referring this issue to a subcommittee to collect data and make recommendations regarding the whole issue. When the Board is in a better position to establish procedures and standards it will do so via the regulatory process. Carriers will, of course, have an opportunity to provide input via the rulemaking process at that time.

Summary of Agency-Initiated Changes

1. N.J.A.C. 11:21-2.1(c) has been clarified to indicate that the Board members elected by Program members are subject to approval by the Commissioner, to bring the Plan into compliance with the requirements of N.J.S.A. 17B:27A-29.

2. N.J.A.C. 11:21-2.2 has been amended to clarify the definition of "Administrator," and remove reference to the administrator being qualified pursuant to a request for proposal. In the definition of "carrier" the word "Act" has been corrected to read "Plan."

3. N.J.A.C. 11:21-2.2 has been revised to include a definition of "deferral" to clarify that term as used in the assessment section of the rules at N.J.A.C. 11:21-2.8(c)3.

4. N.J.A.C. 11:21-2.7(b) has been amended to clarify that the Administrator shall be selected by the Board in compliance with procedures permitted by the public bidding law, N.J.S.A. 52:34-6 et seq. and to clarify that the administrator selected may be either an individual or an entity. The amendment will allow the Board added flexibility in staffing the Program.

5. N.J.A.C. 11:21-2.7(e) has been amended to require recordkeeping in compliance with requirements imposed by the Destruction of Public Records law, N.J.S.A. 47:3-15 et seq. The Board believes such record retention standards are more appropriate than that originally proposed.

6. N.J.A.C. 11:21-2.7(f) as proposed has been deleted and amended to permit the Board to hire such other support office staff as may be necessary to assist the Administrator for the administration of the program.

7. N.J.A.C. 11:21-2.7(d) (erroneously codified as N.J.A.C. 11:21-2.7(g)), stating that compensation for the Administrator would be in accordance with the request for proposal, has been deleted in its entirety, consistent with the changes which were made to N.J.A.C. 11:21-2.7(b).

8. N.J.A.C. 11:21-2.8(c)3 has been corrected to eliminate a typographical error in the word "Procedure."

9. N.J.A.C. 11:21-2.8(c)3 and 2.9(e) have been revised to reflect the citation for regulations adopted by the Department for the assessment deferral procedures referred to in the rules.

10. The codification of the section entitled "Assessment for reimbursable losses" as N.J.A.C. 11:21-2.11 has been corrected as N.J.A.C. 11:21-2.9. The codification of the section entitled "Financial administration" as N.J.A.C. 11:21-2.10 has been corrected as N.J.A.C. 11:21-2.11. The codification of the section entitled "Records" as N.J.A.C. 11:21-2.11 has been corrected as N.J.A.C. 11:21-2.12. The original codification of the sections was the result of clerical error.

11. N.J.A.C. 11:21-2.9(c)7 is revised to correct a citation to a preceding paragraph.

12. N.J.A.C. 11:21-2.9(m) is revised to clarify that the Board will adopt, in subsequent years, certain procedures used to adjust the assessment procedure and proportionate distribution of high risk groups, which will be set forth in the Plan of Operation.

13. N.J.A.C. 11:21-2.12(b) is clarified to reflect that the Board may, from time to time, direct that additional records be maintained, and that the Board shall maintain other records as may be otherwise required by law.

14. N.J.A.C. 11:21-2.14(e) is revised to correct a typographical error in the word "challenge."

15. N.J.A.C. 11:21-2.15(b) is clarified to reflect the Director, officer and employee indemnification procedures to be adopted by the Board will be set forth in the Plan of Operation.

16. N.J A.C. 11:21-2.16(a) is clarified to correct the word "Article" to read "section."

17. N.J.A.C. 11:21-2.16(b) is corrected to capitalize the word "Program" and to correct the word "carrier" to read "member."

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 2. NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM PLAN OF OPERATION

11:21-2.1 Purpose and structure

(a) The Program has been created pursuant to section 12 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-28) as amended by P.L. 1993, c.162, section 6, to provide a mechanism:

1. To assure the availability of five standardized health benefits plans to New Jersey small employers, their eligible employees and the dependents of those eligible employees, on a guaranteed issue basis; and

2. Through which certain losses of specified member companies accruing under the five small employer health benefits plans will be reimbursed by other member companies that are subject to assessments.

(b) The Board has been created pursuant to Section 13 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-29) to administer the Program reasonably and equitably under law.

(c) The Program Plan of Operation ("Plan") has been created in accordance with Section 14 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-30) to set forth as completely as possible the reasonable and equitable manner by which the Board will administer the Program under applicable law.

(d) The Program shall be administered by the Board. The Board shall administer the Program in accordance with the Plan developed and adopted by the Board pursuant to law, subject to the review and approval of the Commissioner of Insurance.

(e) The Board shall consist of 11 persons, including the Commissioners of Health and Insurance or their designees, both of whom shall serve as ex officio, and nine persons who shall be elected by the members of the Program*, **subject to approval by the Commissioner***. Initially, three of the public members of the Board shall be elected for a three-year term, three shall be elected for a two-year term, and three shall be elected for a one-year term. Thereafter, all public members of the Board shall be elected for a term of three years. Filling of vacancies on the Board shall be subject to the approval of the Commissioner of Insurance. No carrier shall have more than one representative on the Board. The following categories shall be represented among the public members:

1. Two carriers whose principal health insurance business is in the small employer market;
2. One carrier whose principal health insurance business is in the larger employer market;
3. A health, hospital or medical service corporation;
4. A health maintenance organization;
5. A risk-assuming carrier;
6. A reinsuring carrier; and
7. Two persons representing small employers.

11:21-2.2 Definitions

The words and terms used in this Plan shall have the meanings set forth at N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1.3, or as further defined below:

"Administrator" means *[any person who meets the qualifications specified in the request for proposal for administering the Program]* ***that person or entity selected by the Board to effectuate the administrative functions of the Program***.

"Board" means the Board of Directors of the Program. As used in this Plan, "Director" shall refer to members of the Board.

"Carrier" means any insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization ("HMO") authorized to issue health benefits plans in this State. For purposes of *[the Act]* ***this Plan***, carriers that are affiliated companies shall be treated as one carrier, except that any insurance company, health service

corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in the State or any health maintenance organization located in the State that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation shall treat the health maintenance organization as a separate carrier.

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

"Deferral" means a deferment, in whole or in part, of payment by a member of any assessment issued by the SEH Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A-38 and N.J.A.C. 11:21-15.

"Department" means the New Jersey Department of Insurance.

"Dependent" means the spouse or child of an eligible employee subject to applicable terms of the health benefits plan covering the employee.

"Earned premium" means the premium earned in New Jersey on health benefits plans less return premiums thereon.

"Eligible employee" means a full-time employee who works a normal work week of 25 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefits plan of a small employer, but does not include employees who work less than 25 hours a week or work on a temporary or substitute basis.

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A-19). "Health benefits plan" excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70.

"Member" means all carriers issuing health benefits plans in this State on or after the effective date of the Act.

"Plan of Operation" means the plan of operation of the Program, including articles, by-laws and operating rules approved by the Board pursuant to the Act.

"Program" means the New Jersey Small Employer Health Benefits Program established pursuant to the Act.

"Reinsuring carrier" means a small employer carrier electing to receive reimbursement from the program in accordance with Section 19 of the Act (N.J.S.A. 17B:27A-35).

"Risk-assuming carrier" means a small employer carrier electing to assume risks pursuant to section 18 of the Act (N.J.S.A. 17B:27A-34).

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State. In determining the number of eligible employees, companies which are affiliated companies shall be consider one employer. Subsequent to the issuance of a health benefits plan to a small employer pursuant to the provisions of the Act, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of the Act which apply to a small employer shall continue to apply until the anniversary date of the health benefits plan next following the date the employer no longer meets the definition of a small employer.

"Small employer carrier" means any carrier that offers health benefits plans covering eligible employees of one or more small employers.

"Small employer health benefits plan" means a health benefits plan for small employers approved by the commissioner pursuant to Section 17 of the Act (N.J.S.A. 17B:27A-33).

"State" means the State of New Jersey.

11:21-2.3 Powers of the Board

(a) The Board has the specific authority pursuant to the Act to:

1. Develop the method to be used to determine the extent to which a reinsuring carrier's payment per insured for each health benefit plan provided for under the Act exceeds the Statewide average payment per insured for each health benefits plan provided for under the Act;

2. Develop the method for determining the extent to which a reinsuring carrier whose average cost of insuring individuals covered by small employer health benefits plans exceeds the threshold described in Section 13(c) of the Act (N.J.S.A. 17B:27A-29(c)) may receive reimbursement from the Program;

3. Develop a statement of the efficiency and risk management standards a reinsuring carrier must meet before a reinsuring carrier may receive reimbursement from the Program;

4. Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Act;

5. Sue or be sued, including taking any legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims;

6. Establish benefit levels, deductibles and copayments, exclusions, and limitations for the health benefits plans in accordance with applicable law;

7. Establish guidelines to ensure that small employer carriers are assuming their share of high risk small employer groups in proportion to their market share of small employer health benefits plan business. In the event that any carrier does not assume its reasonable share of the high risk market, the Board may adjust the assessment formula, with the approval of the Commissioner, to require a proportionally higher assessment from the carrier;

8. Promulgate one standard claim form. In order to provide a standard system of payment for medical services, all claim forms for any claimant's use under a group health insurance policy delivered or issued for delivery in this State shall conform to the form adopted by the Board and promulgated in conjunction with the Individual Health Coverage Program pursuant to P.L. 1993, c.162, Section 20;

9. Assess members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organization and reasonable operating expenses. Such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

10. Establish rules, conditions, and procedures pertaining to the reimbursement and assessment of the members of the Program;

11. Establish a standard policy form for five standard health benefits plans and five rider packages, as provided in the Act;

12. Appoint from among the members appropriate legal, actuarial, and other committees as necessary to provide technical and other assistance in the operation of the Program, policy and other contract design, and any other functions within the authority of the Program;

13. Employ or retain such persons, firms or corporations to perform such functions as are necessary for the Board's performance of its duties. The Board may use the mailing address of such person, firm or corporation as the official address of the Program. Such persons may include an Administrator or executive director with such authority as may be delegated by the Board to implement and carry out broad directives of the Board made pursuant to statutory powers. Such persons may include actuaries, accountants, auditors, insurance producers and such other specialists or persons whose advice or assistance is deemed by the Board to be necessary to the discharge of its duties under the Act. The Board may agree to compensate such persons so as best to serve the interests of the Program and the public. Such persons, firms or corporations shall keep and maintain such records of their activites as may be required by the Board;

14. Develop a method of handling and accounting for assets and moneys of the Program and an annual fiscal reporting to the Commissioner;

15. Develop a means of providing for the filling of vacancies on the Board, subject to the approval of the Commissioner;

16. Address any additional matters which are appropriate to effectuate the provisions of this Act; and

17. Develop a buyers' guide for the Program, and provide for a reasonable charge for its use and distribution.

11:21-2.4 Plan of Operation

(a) The Board shall perform its function under this Plan, and in accordance with the Act. The Plan is intended to assure the fair, reasonable and equitable administration of the Program and shall constitute a public record and accordance with the Act.

(b) The Plan does not, nor is it intended to, created any contractual or other rights or obligations between the Program and any entity or any person insured by any carrier. It does not provide any benefits or create any obligation, contractual or otherwise, to any person or entity.

11:21-2.5 Board structure and meetings

(a) The Program shall exercise its powers through a Board.

1. The Board shall be made up of the Commissioner, the Commissioner of Health, or their designees (who shall serve ex officio) and nine additional persons. The composition of the Board shall be as described in Section 13(a) of the Act. No person representing one of the public members shall serve, or continue to serve, on the Board unless such person represents one of the categories specified in Section 13(a) of the Act (N.J.S.A. 17B:27A-29).

2. Initially, three of the public members shall serve for a term of three years; three shall serve for a term of two years; and three shall serve for a term of one year. Thereafter, all public members shall serve for a term of three years. Vacancies shall be filled in the same manner as the original appointments.

i. On or about 60 days prior to the date of the election meeting, the Board shall send written notice to the Program members setting forth the time, date and place of the election meeting, stating the positions for which a vote is to be taken, soliciting written nominations of candidates for those positions, and stating the last date that written nominations shall be accepted, which shall be no less than 10 business days following the date of the written notice.

ii. Following the close of the nomination period, the Board shall determine from among the carriers and/or small employer representatives nominated those persons that are eligible and willing to serve in the position for which nominated.

iii. At least 30 calendar days prior to the date of the election meeting, the Board shall send a written notice to members setting forth the candidates to be considered for purposes of voting at the election meeting, along with a ballot by which the member carrier may vote absentee on or before a date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting.

iv. Affiliated carriers shall have no more than one vote for each position subject to vote.

v. Elections shall be by a simple majority of those ballots properly cast in person and absentee.

vi. The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at N.J.A.C. 11:21-2.12.

3. The Board may elect a Chair, Vice Chair and Secretary from among its Directors, as well as other officers, as it deems appropriate. The election of officers shall be held annually or more frequently if needed to fill vacancies. Subject to the provisions of the Act and as authorized by the Board, such officers are authorized to serve as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(b) The votes of the Board shall be on a one person, one vote basis. A Director, other than the two small employer representatives provided for in Section 13 of the Act (N.J.S.A. 17B:27A-29), may designate a voting alternate employed by the same carrier or same State agency, as appropriate.

(c) A majority of the Directors shall constitute a quorum for the transaction of business. The acts of the majority of the Directors at a meeting at which a quorum is present shall be the acts of the Board, except as otherwise provided herein.

(d) A meeting of the Board shall be held no later than the first Tuesday in April each year in accordance with the State's Open Public Meetings Act. At that meeting and/or subsequent meetings, the Board shall:

1. Review the financial results for the prior year, including expenses of Program administration and incurred losses, taking into account all other appropriate items; and

2. Determine if an assessment is necessary for the proper administration of the Program.

(e) At least once each year, the Board shall meet to:

1. Review the Plan and submit proposed amendments, if any, to the Commissioner for review;

2. Review reports of the committees established by the Board;

3. Review and approve the rate of interest to be charged for late payments;

4. Review and approve changes in the communications program, as recommended by the Marketing and Communications Committee;

5. Determine whether any technical corrections or amendments to the Act should be recommended to the Legislature;

6. Fill any vacancies among the Directors who represent carriers which exist or which will exist within 10 business days following the date of the election meeting pursuant to a resolution of the Board or the expiration of a Director's normal term of office; and

7. Review, consider, and act on any matters deemed by the Board to be necessary and proper for the administration of the program.

(f) The Board shall hold other meetings upon the request of the Chair or three or more Directors, as deemed appropriate. A meeting may be held in person or by telephone. Notice of such a meeting and its purpose shall be provided to the general public and to the Directors in accordance with the State's Open Public Meetings Act.

(g) The Board shall keep reasonably comprehensive minutes of all its meetings showing the time and place, the Directors present, the subjects considered, the actions taken, the vote of each Director, and any other information required to be shown in the minutes by law. The original of the public record shall be retained by the Board or its agent and shall be promptly available to the public to the extent that making such matters public shall not be inconsistent with Section 7 of the Open Public Meetings Act (N.J.S.A. 10:4-12). At least two copies of the minutes of every meeting of the Board shall be delivered forthwith to the Commissioner.

(h) The Board may establish rules of the Program consistent with the Act and this Plan.

(i) Amendments to the Plan or suggestions for technical corrections to the Act shall require the concurrence of a majority of the entire Board.

(j) Directors shall not be compensated by the Program for their services or related personal expenses.

(k) The Board may adopt rules for the taking of testimony from the public, which may include rules relating to the time and place of any such public hearing, and reasonable rules for the length and format of testimony from individuals, groups and organizations.

(l) The Board may take up any additional matters which are appropriate to effectuate the provisions of this Act.

11:21-2.6 Committees

(a) Appointments to Standing and other committees shall be approved by a majority of the Board present. Each of the Standing Committees shall include no more than five directors, but the Chair may appoint additional persons as needed, with the approval of a majority of the Board. A written record of the proceedings of each committees shall be maintained by a Secretary appointed from the membership of the committee. Committee members are responsible for providing staff support, but may recommend that the Board provide funding for outside contractors. Committees may not take final action; however, within the scope of their mission and duties, Committees may make recommendations and reports to the Board for its decision and action.

(b) Standing Committees shall include the following:

1. A Finance Committee which shall make recommendations to the Board with respect to:
i. The methods and rules for calculating assessments and other risk sharing charges;
ii. Assessment of members in accordance with the provisions of the Act, including such interim assessments as may be reasonable and necessary for organizational and reasonable interim operating expenses;
iii. Establishment of rules, conditions, and procedures pertaining to the reimbursement of the members of the Program;
iv. Independent consulting actuaries who may be approved by the Board;
v. Establishment of rules, conditions, and procedures pertaining to the registry of multiple employer arrangements in accordance with the provisions of the Act; and
vi. Oversight of studies necessary for development of reinsurance mechanisms;
2. An Operations Committee which shall make recommendations to the Board with respect to:
i. The Plan and amendments thereto;
ii. A uniform reinsurance compliance audit program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier;
iii. The selection of an independent auditor for the annual audit of the Program operations;
iv. The review of reports prepared by independent auditors and other audit-related matters the Board deems necessary;
v. Contracts which are necessary or proper to carry out the provisions and purposes of the Act;
vi. Developing the means to select a plan administrator, a statement of the powers and duties of the Administrator, the compensation of the Administrator, and a statement of the efficiency standards an Administrator must meet; and
vii. Recommendations for employing or retaining persons, firms or corporations to perform the functions necessary for the Board's performance of its duties, including retention of an Administrator for the Program;
3. A Legal Committee which shall make recommendations to the Board with respect to:
i. Appropriate interpretations of the Act, and such other matters as the Board may desire, including rules and regulations promulgated by the Board pursuant to the Act;
ii. Amendments to the Plan, and the various health benefits plans proposed by the Board for compliance with the Act, and by implication under Federal or other State legislation;
iii. Proposed amendments to the Act for Board approval;
iv. Contracts and legal documents for the Program;
v. All litigation and other disputes involving the Program and its operations;
vi. Maintenance of a written record of all questions received and responses provided by the Board;
vii. Coordination with legal counsel for the Board, as needed, on matters relating to the Program operations, including proposed contracts, operational practices, and statutory construction;
viii. Any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the Program or a member;
ix. The Board's entering into contracts necessary or proper to carry out the provisions and purposes of the Act; and
x. Legal actions as may be necessary for recovery of any assessments due to the Program or to avoid paying any improper claims and other matters related to lawsuits by or against the Board;
4. A Marketing and Communications Committee which shall make recommendations to the Board with respect to:
i. Rules for implementation and administration of the Act and standards to provide for the fair marketing and broad availability of health benefits plans to eligible employees;
ii. Marketing and communication plans for the Program, as needed;
iii. Issues or concerns arising out of the marketing of Program coverage;
iv. The development of information concerning the Program to be released to the general public; and
v. Reviewing marketing material submitted by carriers in accordance with the Act; and
5. A Dispute Resolution Committee which shall make recommendations to the Board with respect to:
i. Consumer, policyholder and member carrier inquiries, complaints and disputes arising in connection with the Program;
ii. The manner by which the Board may address inquiries, complaints and disputes brought to its attention;
iii. Procedures for receiving, logging and handling inquiries, complaints and disputes;
iv. The design of inquiry, complaint and dispute forms;
v. Procedures for carriers to use in notifying the Board of complaints and disputes;
vi. Whether and how to respond to interpretations of the Board's rules made by carriers and inquiries and complaints received from consumers, policyholders, carriers or others.
(1) Recommendations by the Dispute Resolution Committee may include a recommendation that the Board isssue a statement interpreting its regulations, seek declaratory or injunctive relief as may be appropriate, or other administrative or legal remedies as may be available.
(2) In an effort to answer any inquiry or resolve any dispute or complaint, the Dispute Resolution Committee or Administrator may seek the input of other appropriate Committees in order to assist the Dispute Resolution Committee in reaching a recommendation.
(3) The Dispute Resolution Committee may refer matters as necessary to any other Committee which may also make recommendations to the Board.
(4) The Dispute Resolution Committee or Administrator shall compile statistics on complaints, disputes and appeals received and resolved and submit an annual report to the Board and the Commissioner detailing the volume of complaints, disputes and appeals categorized by type, carrier and disposition.
(5) Nothing in this paragraph shall be deemed to impair or otherwise affect the authority of the Commissioner to investigate and resolve any complaint or dispute or to take any regulatory or enforcement action with respect to any violations of any State insurance statutes or rules which come to the Commissioner's attention.
(c) The Board may appoint other committees. The Board may by resolution adopted by a majority of the entire Board:
1. Determine the size of and appoint members to and/or fill any vacancy in any committee;
2. Appoint one or more persons to serve as alternate members of any committee, to act in the absence or disability of members of any committee with all the powers of such absent or disabled members;
3. Abolish any committees, in its discretion;
4. Remove any person from membership on any committee at any time, with or without cause; and
5. Authorize or appoint the use of consultants or other advisors to work with any committee.

11:21-2.7 Administrator selection and duties
(a) The Administrator shall be selected by the Board.
(b) The Administrator shall be selected by *[a bidding process. The Board shall issue a Request for Proposal with written criteria for selection of a qualified person and shall solicit responses from carriers participating in the small group market and other qualified persons]* ***the Board in compliance with the public bidding law, N.J.S.A. 52:34-6 et seq***.
(c) The Administrator shall perform the administrative functions required under the Act and the Plan. The Administrator is responsible, along with the Board, for the fair, equitable and reasonable administration of the Program.
(d) The Administrator shall perform all administrative functions developed by the Board including the following:
1. Preparing and submitting an annual report to the Board and the Commissioner no later than the third week of March; preparing and submitting monthly reports to the Board;

2. Establishing the procedures and installing the systems needed to properly administer the operations of the Program;

3. Establishing with Board approval, one or more depository accounts for the transaction of Program business;

4. Collecting assessments due to the Program on a timely basis;

5. Depositing all moneys collected on behalf of the Program in the established depository account(s) on a timely basis;

6. Reimbursing reinsuring carriers following their submission of acceptable documentation;

7. Issuing checks or drafts, on and/or approving charges against, bank accounts of the Program;

8. Keeping all accounting, administrative and financial records of the Program;

9. Acting as a resource for reinsuring carriers in complying with the Program;

10. Calculating all assessments in accordance with the methodology approved by the Board; notifying members of amounts due; tracking the amount of assessments in dispute or subject to deferral request; coordinating with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters;

11. Preparing an annual estimate of the operating and administrative expenses of the Program;

12. Preparing a detailed Operations and Procedures Manual which must include forms and procedures for processing business as required by the Plan;

13. Based on minimum standards for participation in the Program as a reinsuring carrier developed by the Board, reviewing compliance with such standards; and

14. Performing other functions as agreed between the Board and the Administrator.

(e) The Administrator shall maintain calendar year records of premiums, reimbursements, and operating and administrative expenses and shall retain these records for a period of seven years following the end of such calendar year ***or as otherwise required pursuant to N.J.S.A. 47:3-15 et seq***.

(f) *[The Administrator shall serve for a period of three years, or until it is otherwise removed by the Board. The Administrator may request to terminate its contract and must give the Board 180 days notice. The Board must act upon the Administrator's request within 90 days of its receipt or the request is considered approved.]* ***The Board may select, and establish compensation for, such other staff as may be necessary for the administration of the Program.***

[(d) The Administrator shall be reimbursed as set forth in the request for proposal.]

11:21-2.8 Assessments for administrative and operating expenses

(a) Annually on or about April 15, the Board shall determine the final administrative expense total for the preceding calendar year, if any.

1. Each member's final assessment shall be reduced by any interim assessment paid by the member or credited to the member by the Board.

2. Each member's final assessment shall be reduced by any deferred assessments paid by assessed carriers in proportion to the original additional assessment made to cover the deferred amount.

3. Members shall be assessed for a proportionate share of the final administrative expenses on the basis of health benefits plan earned premiums for that year. The administrative expense assessement for each member shall be equal to the total of all administrative expenses for the calendar year multiplied by the ratio of that member's earned premium for health benefits plans to the earned premium for health benefits plans of all members for the calendar year.

(b) The Board may make an interim assessment of members for reasonable and necessary organizational expenses and to cover anticipated interim operating expenses. At the discretion of the Board, interim assessments may be made on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses.

(c) Assessment amounts are due and payable upon receipt by a member of the invoice for the assessment. Payment shall be by bank draft made payable to the Treasurer—State of New Jersey, SEH Program, c/o The New Jersey Department of Insurance, 20 W. State Street, CN-325, Trenton, NJ 08625.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 45 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent of the assessment amount not timely paid per month, accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment, for which an interest penalty amount has accrued, shall include the interest penalty amount accrued as of the invoice date; otherwise, payment shall not be considered to be in full.

2. Carriers that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the Board, shall be assessed for and make payment of the full amount of the assessment invoice, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that carrier, or, if a contested case, the Board has rendered a final determination in favor of that carrier in accordance with the Administrative Procedure*[s]* Act, N.J.S.A. 52:14B-1 et seq.

3. A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with *[procedures established by the Commissioner]* ***N.J.A.C. 11:21-15***.

i. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice to be held in an interest bearing escrow account in accordance with the procedures set forth herein, pending final disposition by the Commissioner of the deferral request.

ii. If the member withholds payment, as permitted herein and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth herein, accruing from the date of the invoice for the assessment.

4. Amounts deferred by the Commissioner or subject to dispute, which dispute is resolved in favor of the carrier, shall be redistributed among all other members proportionately.

(d) The Administrator shall coordinate with the Department and other appropriate parties, including State agencies, regarding fiscal administrative matters, and develop appropriate procedures for such matters, and disburse funds for administrative expenses upon the directive of the Board.

1. Amounts of assessment in dispute or subject to deferral request, including any interest penalty paid by a carrier pursuant thereto, shall not be disbursed by the Administrator until such time as the dispute has been settled against the disputing carrier, or the deferral denied, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed immediately according to Board directive.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing carrier, or a deferral is granted, shall be returned to the appropriate carrier within 15 days of the date that the Administrator receives notice of the determination by the Board or the Commissioner, as applicable, along with the proportionate amount of interest penalty, if any, paid by the carrier for late payment of the amount.

(e) A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the Administrator in order to preserve its right to the moneys owed and paid pursuant to the invoice for assessment.

(f) If a member determined liable for an assessment fails to pay the full amount of the assessment and applicable interest, if any, within 60 days of the date of the invoice, and has neither submitted

notice that it is seeking a deferral from the Commissioner, nor requested a hearing, the Board may provide to the Commissioner a notice of the member's failure to make payment along with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State or to take such other action against the carrier as may be authorized by law. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

11:21-*[2.11]***2.9*** Assessment for reimbursable losses

(a) The Board shall determine the total reimbursable losses, which shall be the net loss of the Program, if any, for the calendar year based upon the information submitted by reinsuring carriers annually on or before August 15 to the Board beginning in 1995. Such a determination shall be made by the Board on or about October 1 annually.

(b) The total reimbursable losses for the year shall be the aggregate of the reimbursable losses for all reinsuring carriers reporting reimbursable losses.

(c) Reinsuring carriers shall be liable for a portion of the reimbursable losses. A reinsuring carrier's assessment amount shall equal reimbursable losses but shall not exceed four percent of the earned premiums for small employer health benefits plans for any reinsuring carrier.

1. Each reinsuring carrier's assessment amount shall be determined by multiplying the total assessment amount by the ratio of the reinsuring carrier's earned premiums for that calendar year for small employer health benefits plans to the total earned premiums for that calendar year for all reinsuring carriers for small employer health benefits plans.

2. The Board shall provide notice to reinsuring carriers in writing on or about October 1 of the total reimbursable losses for the year and whether the reinsuring carrier may be liable for a portion of the total reimbursable losses.

3. The Board shall notify each reinsuring carrier of the assessment and reimbursement for reimbursable losses by invoice stating the dollar amount then due by November 1. As a result of the assessment, any monies determined to be owed to or by the Board shall be calculated without provision for interest.

4. Assessment amounts for reinsuring carriers granted a deferral by the Commissioner, or subject to dispute by a carrier wherein the dispute is settled in favor of the disputing carrier, shall be apportioned to other reinsuring carriers based on their respective share of earned premiums for small employer health benefits plans.

5. A reinsuring carrier's assessments in amounts exceeding four percent of earned premiums shall be apportioned to all small employer carriers based upon their respective share of small employer health benefits plan earned premiums until such other members reach one percent of small employer health benefits plan earned premiums or the total reimbursable losses are fully assessed, whichever occurs first.

6. If a member that is not a reinsuring carrier demonstrates that it would have qualified for reimbursable losses if it had elected to be a reinsuring carrier, such carrier shall be eligible for a reduction in its assessment. Said reduction shall be equal to 1.00 minus the carrier's ratio of its earned premium for small employer health plans to the total earned premium for small employer health plans divided by the ratio of the carrier's reimbursable loss calculated above to the total of all calculated reimbursable losses. In no event shall this calculation cause the assessment to be increased.

7. Reductions in assessments made according to (c)*[5]***6*** above shall be apportioned to other members until such other members are assessed one percent of small employer health benefits plan earned premiums.

(d) Assessment amounts are due and payable upon receipt of an invoice by a member for the assessment. Payment shall be by bank draft made payable to the Treasurer—State of New Jersey, SEH Program, c/o the New Jersey Department of Insurance, 20 W. State Street, CN-325, Trenton, NJ 08625.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent per month of the assessment amount or any portion thereof not timely paid, accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. If a member makes an error relating to or involving an assessment or any other error resulting in non-payment or underpayment of funds, the member shall make immediate payment of additional amounts due. Errors that are reported and paid in full to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth above.

2. Carriers that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the Board shall be assessed for and make payment of the full amount of the assessment invoice when due, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that carrier, or, if a contested case, the Board has rendered a final determination in favor of that carrier in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(e) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with *[procedures established by the Commissioner]* ***N.J.A.C. 11:21-15***.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice to be held in an interest bearing escrow account in accordance with the procedures set forth herein, pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted herein, and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth herein, accruing from the date of the invoice for the assessment.

(f) The Board shall approve the disbursement of any payments to those members determined by the Board as having reimbursable losses. Disbursement shall be in proportion to the member's share of the total reimbursable losses, until all such available funds have been paid out, or a member's reimbursable losses have been reimbursed, whichever comes first.

1. Amounts of assessment in dispute or subject to a deferral request shall not be disbursed to members having reimbursable losses until such time as the dispute has been settled or concluded with the disputing carrier, or the deferral denied, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable losses along with any applicable interest penalty amounts paid or interest earned while held in escrow by the Board.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing carrier, or a deferral is granted, shall be returned to the appropriate carriers within 15 days of the date that the Administrator receives notice of the determination by the Board or the Commissioner, as applicable, along with the proportionate amount of interest penalty, if any, paid by the carrier or late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board.

(g) Assessment amounts shall be redistributed to the appropriate reinsuring carriers for their losses on or about December 1 of each calendar year.

(h) A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the Administrator in order to preserve its

right to the moneys owed and paid pursuant to the invoice for assessment.

(i) If a member determined liable for an assessment fails to pay the full amount of the assessment and applicable interest, if any, within 60 days of the date of the invoice, and has neither submitted notice that it is seeking a deferral from the Commissioner, nor requested a hearing, the Board may provide to the Commissioner a notice of the member's failure to make payment along with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State or to take such other action against the carrier as may be authorized by law. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

(j) A reinsuring carrier may apply to the Board for reimbursement from the program if such reinsuring carrier demonstrates to the Board that it has satisfied the efficiency and risk management standards promulgated by the Board, as set forth herein, and demonstrates it has incurred an average cost of insuring individuals covered by small employer health benefits plans that exceeds the Statewide average payment per insured by 20 percent. A reinsuring carrier satisfactorily demonstrating it has met these threshold standards may seek reimbursement from the Program for the lesser of its actual losses or 80 percent of the excess of its incurred claims over 120 percent of the Statewide average payment per insured, as defined herein, multiplied by the number of insured months for the reinsuring carrier.

(k) Before a member may receive reimbursement from the Program, the member must demonstrate to the Board's satisfaction, subject to its review and audit by the Board, that it has conducted its business operations with respect to administering its small employer health benefits plans in accordance with generally accepted industry practice and has made good faith efforts to apply sound risk management principles in an efficient manner.

1. Such risk management and efficiency standards shall include, but are not limited to, claim processing and payment practices showing the member has:

i. Paid or declined for payment 85 percent of all claims within 10 working days from the date the completed submission was received;

ii. Reviewed a statistically valid sample of claims on a regular basis for accuracy and proper use of the reimbursement methodology, with dollar accuracy, without allowance for offsets of over/under payments, being at least 99.0 percent; and

iii. Responded to all inquiries from insureds or covered individuals within 30 business days.

2. A member shall apply its case management and claims handling techniques and other methods of operation in the same manner with respect to all its business.

(l) Statewide average payment per insured means the ratio of the claims incurred in the calendar year for all members to the total number of insured months for that calendar year for all members calculated separately for each small employer health benefits plan.

1. A carrier's average payment per insured means the ratio of the claims incurred in the calendar year to the total number of insured months for that calendar year calculated separately for each small employer health benefits plan.

2. The extent to which that carrier's average payment per insured for the small employer health benefits plan exceeds the Statewide average payment per insured for the small employer health benefits plan shall equal the difference between the carrier's average payment per insured and the Statewide average payment per insured for a given small employer health benefits plan.

3. The calculations shall be performed after the close of the calendar year at a time which the Board establishes that most claims incurred will have emerged.

(m) In order to ensure small employer carriers are assuming their share of high risk employer groups in proportion to their share of the small employer health benefits plan business, the Board shall charge the appropriate Committee(s) with conducting a survey of the market beginning sometime after the first full calendar year of operation under the Program to measure and define the proportion of high risk small employer groups within the small employer group health market and to determine the distribution of such groups among the members in the market. Based on this survey, the Board shall request that the appropriate Committee(s) assess the reasons for any member's disproportionately low share of such high risk groups.

1. Based on the findings, the Board shall consider appropriate steps to ensure each member's share of the high risk market is proportionate to its total small employer health benefits plan business and shall, based upon the survey data, direct the Finance Committee to develop suitable mechanisms for adjusting the assessment formula to require a proportionately higher assessment for members not assuming their reasonable share of the high risk market. The Board shall further determine the best means of regularly ensuring the proportionate distribution of high risk groups among members for subsequent years of the Program's operation.

2. The Board shall set forth within this Plan the standards and procedures used to adjust the assessment formula and/or means to ensure the proportionate distribution of high-risk groups in subsequent years.

11:21-2.10 Reporting requirements

Carriers shall submit statements, assessments and other reports as may be required by the Board pursuant to the Act.

11:21-*[2.10]****2.11*** Financial administration

(a) The Board shall maintain the books and records of the Program so that financial statements can be prepared to satisfy the Act. Further, these books shall satisfy any additional requirements of the Board and outside auditors.

1. The receipt and disbursement of cash by the Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when assets or liabilities should be realized by the Program in accordance with generally accepted accounting principles.

3. Assets and liabilities of the Program, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to or from the Program shall be calculated for each carrier and confirmed as deemed appropriate by the Board or when requested by the respective carrier. These balances should be supported by a record of each individual carrier's financial transactions with the Program. These records include:

i. Net losses of the Program calculated in accordance with this Plan;

ii. Any adjustments to assessments as explained in this Plan;

iii. Adjustments to the amount due to/from the Program based upon corrections to carrier submissions;

iv. Interest charges due from a carrier for late payment of amounts due to the Program; and

v. Other records required by the Board.

5. The Board shall maintain a general ledger which balances are used to produce the Program's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledgers or journals.

6. Assessments shall be paid when billed. If the assessment is not received by the Board within 45 days of the invoice date, the carrier shall pay interest on the assessment from the invoice date at the rate of 1.5 percent per month except if the carrier is granted a deferral.

(b) All funds of the Program shall be deposited in, and all disbursements made from, the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget, and all financial records shall be kept in a form acceptable to the Office of Management and Budget.

1. Funds of the Program shall be deposited into a dedicated account within the General Fund.

2. Moneys shall be credited from the General Fund, with the approval of the Director of the Division of Budget and Accounting, to the Program's bank accounts upon request by the Board through the Department, which request shall include a justification for the request, with supporting documentation.

3. The Administrator shall make such requests for funds as directed by the Board and shall deposit all moneys received from the Treasury in a Board bank account.

(c) Bank checking accounts shall be established separately in the name of the Program and shall be approved by the Board.

1. The Board shall authorize individuals to sign checks on behalf of the Board.

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law. All investment income earned shall be credited to the Program and shall be applied to reduce future assessments of members for the Program losses and administrative expenses.

11:21-*[2.11]**2.12* Records

(a) The Board shall provide for the maintenance and retention of its official records in accordance with the Destruction of Public Records law (N.J.S.A. 47:3-15-32) and all other applicable laws.

(b) The Board's records shall include the following:

1. Minutes of all Board meetings;

2. Written reports and recommendations of committees to the Board;

3. Informational and other filings made by carriers with the Board pursuant to the Act or the Board's rules;

4. Riders proposed or adopted by the Board, including all comments received;

5. The Plan of Operation and any amendments thereto;

6. Records concerning the election of Directors and appointment of committees and committee members; *[and]*

7. Regulations or actions proposed or adopted by the Board, including all comments received*[.]* ***; and***

8. Such other specific records as the Board may from time to time direct or as may be required by law.

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to the "Right-To-Know" Act (N.J.S.A. 47:1A-1 et seq.) except that information in filings determined by the Board by regulation to be confidential and proprietary shall not be subject to public inspection and copying.

(d) For the purpose of disseminating information about the Program, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of member carriers initially shall be based upon the member carriers' addresses filed with the Department pursuant to N.J.A.C. 11:1-25. The Board may proceed to develop its own list of member carriers.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided above, the name and address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

2. Persons other than member carriers who wish to receive communications from the Board, including proposed rules, actions and public notices, may request to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

11:21-2.13 Audit functions

(a) The necessity for and the frequency of audits of carriers shall be determined by the Board. The reasonable cost of the audit of a carrier shall be borne by that carrier. The Board shall have the right to conduct appropriate additional audits of carriers.

1. All information disclosed in the course of the audit of a carrier shall be kept privileged and protected by the carrier, the auditing firm, and the Program, to the extent permitted by law.

2. Any information disclosed in the course of the audit may be used by the Board or Department to effectuate the provisions of this Act.

(b) The Program shall have an annual audit of its operations conducted by an independent certified public accountant approved by the Board. This audit shall encompass at least the following items:

1. The handling and accounting of assets and money for the Program;

2. The annual fiscal report of the Program; and

3. The calculation and collection by the Program of any assessments of carriers for net losses.

11:21-2.14 Penalties/adjustments and dispute resolution

(a) Numerous factual determinations and tasks shall be performed by carriers relative to their participation in the Program. It is expected that all carriers will exercise good faith and due diligence in all aspects of their relationship with the Program. Errors may occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

1. Carrier errors related to assessments shall require the immediate payment of additional amounts due plus interest, calculated from the date such sum should have been paid, except as provided herein.

2. All other additional sums due to the Program as a result of errors made by carriers shall be paid immediately, with interest.

3. If the Board determines that the nature or extent of errors made by a particular carrier evidences gross negligence or intentional misconduct, the Board may, after notice, recommend to the Commissioner, Attorney General, and other appropriate officials, penalties and sanctions as may be appropriate in accordance with the Act.

4. All interest payments required under this Plan shall be calculated at 1.5 percent per month, from the date the incorrect payment occurred or a payment should have been made, through the date the correct payment is made. Errors reported by carriers within 60 days of their occurrence shall not be subject to interest.

(b) A carrier seeking to challenge the amount of an assessment shall do so within 20 days of receiving the notice of assessment following the procedures in (d) below.

(c) A carrier which disputes being subject to an assessment and wishes to contest that issue shall file its appeal with the Board no later than 20 days after receiving the notice of assessment following the procedures in (d) below.

(d) Concurrent with its challenge to the assessment, a carrier shall advise the Board in detail of the reasons why the assessment is inaccurate or not appropriate and shall submit all documentation that supports or tends to support the carrier's position. The carrier shall also advise at this time whether a hearing is requested.

(e) If a hearing is requested, within 30 days of its receipt thereof, the Board shall determine whether the matter constitutes a contested case. If the matter is determined to be a contested case, the Board shall determine whether to hear the matter or refer it to the Office of Administrative Law for a hearing pursuant to 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. If the matter does not constitute a contested case, the Board shall review the *[challange]* ***challenge*** itself or delegate this review to an appropriate Committee to make a recommendation to the Board.

11:21-2.15 Indemnification

(a) The Board shall not be liable for any obligation of the Program. No Director, officer, or employee of the Board or the Department or Department of Health shall be individually liable and no cause of action of any nature may arise against them, for any action taken or omission made by them unless their conduct was outside the scope of their employment or constituted a crime, actual fraud, actual malice or willful misconduct.

(b) The Program shall adopt additional procedures for indemnifying the Directors and any officers or employees, as the Board deems appropriate*, **which procedures shall be so forth in this Plan***.

11:21-2.16 Amendment and termination

(a) This Plan may be amended by a majority vote of the entire Board, subject to approval of the Commissioner as provided hereinafter. A vote on an amendment may be taken at any meeting called, in whole or in part, for the purpose of considering a proposed amendment. Written notice of any meeting at which at amendment to the Plan is to be considered shall be sent to each Director by mail or facsimile transmission at least 10 days (exclusive of the meeting day) prior to the date of the meeting. Such notice shall state that an amendment to the Plan is to be considered at the meeting and shall set forth the substance of any amendments which have been proposed or a description of the section or sections which are proposed to be amended. Notice to a Director shall be deemed sufficient if mailed, postage prepaid, to the most recent address provided by the Director to the Board or sent by facsimile transmission to the most recent facsimile reception number provided by the Director. At any meeting for the consideration of an amendment to the Plan, for which proper notice has been given pursuant to this *[Article]* ***section***, the Board may vote on any amendment proposed by a Director prior to, or during the meeting. Any amendment adopted by the Board shall be submitted to the Commissioner for approval. Any such amendment submitted to the Commissioner shall be deemed approved no later than 90 days after receipt by the Commissioner unless expressly disapproved in writing by the Commissioner before expiration of the approval period. Amendments to the Plan must be adopted pursuant to P.L. 1993, c.162.

(b) The *[program]* ***Program*** shall continue in existence subject to termination in accordance with the laws of this State or the United States of America. In case of enactment of a law or laws which, in the determination of the Board and the Commissioner, shall result in the termination of the *[program]* ***Program***, the *[program]* ***Program*** shall terminate and conclude its affairs. Any funds or assets held by the *[program]* ***Program*** following the payment of all claims and expenses of the *[program]* ***Program*** shall be distributed to the *[carriers]* ***members*** at that time in accordance with the then-existing assessment formula.

(a)

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program

Adopted Amendments: N.J.A.C. 11:21-1.2 and 4.1, and Exhibits A, F, G, H, I and K of the Appendix to N.J.A.C. 11:21

Adopted New Rules: Exhibits V, W, X, Y, Z and AA to the Appendix to N.J.A.C. 11:21

Proposed: October 6, 1993 in accordance with P.L.1993, c.162, Section 16 at 25 N.J.R. 5017(a).

Adopted: December 15, 1993 in accordance with P.L.1993, c.162, Section 16 by the New Jersey Small Employer Health Benefits Program Board, Maureen Lopes, Chair.

Filed: December 22, 1993 as R.1994 d.47, **with substantive and technical changes** not requiring additional public notice or comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17B:27A-30, as amended by P.L.1993, c.162, Section 16.

Effective Date: December 22, 1993.

Expiration Date: October 15, 1998.

These new rules were proposed and are being adopted pursuant to the procedures set forth at P.L.1993, c.162, Section 16, as therein authorized.

Accordingly, notice of the proposal of these new rules was sent for publication in three newspapers of general circulation in New Jersey, mailed to all known interested parties, and submitted to the Office of Administrative Law (OAL) for publication in the New Jersey Register.

Pursuant to P.L.1993, c.162, Section 16, interested parties were provided a comment period of at least 15 days. As set forth in the notice of proposed new rules, the comment period ended on November 8, 1993. Pursuant to P.L.1993, c.162, Section 16, a public hearing on the rules was held by the Small Employer Health Benefits Program Board, on November 3, 1993. A copy of the transcript of the proceeding can be obtained by interested parties by contacting the Interim Administrator, New Jersey Small Employer Health Benefits Program, SEH Box 1 c/o The Prudential Insurance Company of America, P.O. Box 4080, Iselin, N.J. 08830.

Written comments were received. Not all comments received were responsive to the proposed rules. The Board has responded only to those comments specifically relevant to the proposal.

Summary of Public Comment and Agency Responses:

The Small Employer Health Benefits Program received timely comments from the following:

Association of Community Cancer Centers
Neil Weisfeld, Medical Society of New Jersey
David A. Banta, Pharmaceutical Manufacturers Association
Hackensack Medical Center
Senator Jack G. Sinagra
Mark S. Pascal, M.D., The Oncology Society of New Jersey
William F. Megna, Esq., LeBoeuf, Lamb, Leiby and Mac Rae for American Family Life Insurance Company of New York.

COMMENT: One commenter objected to inclusion of major peer-reviewed literature as the standard for recognizing coverage for "off-label" drugs. The commenter stated that sound data from clinical abstracts could be available but not yet published in a journal. The commenter believes that the major peer-reviewed literature standard is too restrictive since information may be obtained from other sources such as oncology journals from European countries, Australia and South Africa.

RESPONSE: The Board has an obligation to institute standards which are reasonable both in terms of administration by carriers, and the promotion of the health and well-being of persons covered under small employer health benefits plans. Clearly, a level of subjectivity will be required since there exists no definitive standards for determining when off-label drug use is appropriate. The Board has attempted to minimize the potential for individual company subjectivity by requiring carriers to rely on specific compendia and major peer-reviewed literature, rather than making determinations as to whether data in a clinical abstract is sound or whether oncology journals from other countries are acceptable while others are not. In doing so, the Board has relied upon previous public comment and the expertise within the New Jersey Department of Health. The Board does not believe that the proposed standards are contrary to the public good. Therefore, no change will be made in the language as proposed.

COMMENT: One commenter objected to the provision which permits coordination of benefits with hospital confinement indemnity benefits in excess of $250.00 per day. The commenter stated that these plans are designed to cover expenses not covered by medical expense insurance. The commenter also stated that the formula contained in N.J.A.C. 11:21-1.2 is inconsistent with the formula adopted by Individual Health Coverage Board.

RESPONSE: The Board disagrees with the commenter's suggestion that there be no coordination with such plans. Coordination of benefits provisions are standard components of group medical plans and are intended to prevent reimbursement beyond incurred covered charges. The formula contained in N.J.A.C. 11:21-1.2 is consistent with the formula adopted by the Individual Health Coverage Board and no further change is necessary.

COMMENT: Two commenters requested that the language dealing with coverage for off-label drugs be consistent with the provisions of Senate Bill 1631 which is currently pending before the New Jersey Legislature.

RESPONSE: In the event Senate Bill 1631 is approved by the Legislature, the plans will be amended to conform with the legislation applicable to all insured medical plans in the State of New Jersey. The Board has attempted to balance the needs of individuals, small employers and carriers and has adopted language which it believes to best protect these interests. No change will be made at this time in the proposed language.

COMMENT: Four commenters requested deletion of the preponderance of evidence standard in peer-review literature in determining whether to recognize coverage for "off-label" drugs. Several commenters stated that this standard has a strict legal meaning that would severely restrict what physicians can prescribe. Other commenters questioned whether this would result in a quantity standard instead of a quality standard in determining whether a preponderance of evidence exists.

RESPONSE: The Board is concerned with the appropriateness of utilization of off-label drugs where contradictory medical studies exist. The Board believes that the preponderance of evidence standard will best serve to protect the individual patient in recognizing coverage for off-label drugs. It is not the Board's intent that quantity carry more weight than quality with respect to the peer-review literature, but rather anticipates that the two qualifiers will be linked. No change will be made in the language as proposed.

COMMENT: Two commenters requested that coverage for autologous bone marrow transplant for the treatment of breast cancer be extended beyond National Cancer Institute approved clinical studies to cover any clinical trial. One commenter recommended extension of such coverage to recognize clinical studies conducted by cooperative oncology groups. This commenter stated that the New Jersey Department of Health is currently working on certificate of need guidelines for bone marrow transplant centers in New Jersey.

RESPONSE: The Board evaluated information received from both independent oncologists and carrier medical directors concerning bone marrow transplants for treatment of breast cancer. The Board believes that the proposed extension of coverage to National Cancer Institute sponsored clinical trials is most appropriate at this time. The Board will monitor the study by the New Jersey State Department of Health which is presently considering certificate of need guidelines. The Board will also continue to work with medical professionals to monitor further developments with clinical trials. No further change will be made in the benefit plans at this time.

COMMENT: One commenter objected to carriers having the ability to establish alternative methods of utilization review without physicians being made aware of the changes. The commenter further stated that the utilization review process should have adequate protection such as: a medical advisory committee; all reviews to be conducted in-State by specialists; reviewers should be required to respond within reasonable time frames and not to act intrusively; and utilization review should be complemented by a patient complaint mechanism monitored by the Board.

RESPONSE: While the Board has permitted carriers to utilize alternative review procedures, the carrier must obtain prior approval of the Board for such procedures. Moreover, the Board is proposing regulations to establish standards for Board review and approval of alternate utilization review procedures, proposed as N.J.A.C. 11:21-4.3. If approved, these provisions will clearly be included in both the employer's health benefits plan and the employee's certificate booklet. The Board may utilize the advice of experts in reviewing any such filings.

The Board does not believe that all reviews must be conducted in the State of New Jersey. The paramount concern should be that the review criteria are should and implemented by appropriate medical professionals, not that reviewers be physically located in a given location. In reviewing any alternative filings the Board will evaluate the time frames for response by reviewers, as well as all other aspects of the utilization review features. Each carrier must establish an appeal procedure for any appeals under the plan as required by Federal law for employer plans subject to ERISA. (In addition, a complaint procedure is provided for in the Small Employer Health Benefits Program Plan of Operations should an aggrieved individual feel a need to go beyond the carrier.)

The Board believes that the prior approval requirement will provide the necessary protection for insured employees. Therefore, no change will be made in the proposal.

Summary of Agency-Initiated Changes:

1. Exhibits G and Y to N.J.A.C. 11:21 have been amended to clarify certain terms for technical accuracy because Exhibits G and Y pertain to HMO contracts, as distinct from terms used in an insurance policy. The technical corrections change "insurance policy" to "contract," "insured" to "covered," "insurance" to "coverage," "be paid" to "receive" and "overinsurance" to "excessive coverage."

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in cursive brackets with asterisks *[thus]*):

SUBCHAPTER 1. GENERAL PROVISIONS

11:21-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

...

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A-19). For purposes of this act, "health benefits plan" excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.). A "health benefits plan" also does not include any group or group type supplemental hospital indemnity benefits program wherein the benefit does not exceed $250.00 per day. A hospital indemnity benefits program does not fail to meet the test therein so long as the benefit paid for the first two days of hospitalization does not exceed that which would be paid under the following formula:

$$\frac{\text{1st day benefit} - \text{2nd day benefit}}{5} + \text{2nd day benefit} \leq \$250$$

...

SUBCHAPTER 4. POLICY FORMS

11:21-4.1 Policy forms

(a) Members shall use the standard policy forms for Plans A, B, C, D and E which are set forth in the Appendix to this chapter as Exhibits A through F, subject to the "Explanation of Brackets (Plans A, B, C, D)" set forth in Exhibit K, Part 1 of the Appendix, incorporated herein by reference.

1. Notwithstanding (a) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A-17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21-1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.

(b) Members shall use the standard policy form for HMO Plan which is set forth in the Appendix to this chapter as Exhibit G, subject to the "Explanation of Brackets (HMO Plan)" set forth in Exhibit K, Part 2 of the Appendix, incorporated herein by reference.

1. Notwithstanding (b) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A-17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21-1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.

(c)-(d) (No change.)

(e) Members shall use the standard small group health benefits certificate for Plan A which is set forth in the Appendix to this chapter as Exhibit V, subject to the "Explanation of Brackets—Certificate Forms" set forth in Exhibit X, Part 1 of the Appendix, incorporated herein by reference.

(f) Members shall use the standard small group health benefits certificate for Plans B, C, D and E which is set forth in the Appendix to this chapter as Exhibit W, subject to the "Explantion of Brackets—Certificate Forms" set forth in Exhibit X, Part 1 of the Appendix, incorporated herein by reference.

(g) Members shall use the standard employee evidence of coverage for HMO Plan which is set forth in the Appendix to this chapter as Exhibit Y, subject to "Explanation of Brackets (HMO Plan)" set forth in Exhibit X, Part 2 of the Appendix, incorporated herein by reference.

(h) Members shall use the Rider—Certificate Forms for Plans B, C, D and E as set forth in the Appendix to this chapter as Exhibit Z, Part 1, "Card/Mail"; Part 2, "Card"; Part 3, "Mail"; and Part 4 "Mental and Nervous Conditions and Substance Abuse Benefits."

(i) Members shall use the Riders—Employee evidence of coverage for HMO Plan as set forth in the Appendix to this chapter as Exhibit AA, Part 1, "Card/Mail"; Part 2, "Card"; and Part 3, "Mail."

(j) All small group health benefits certificates and employee evidences of coverage issued to employees covered under small employer health benefits plans on and after January 1, 1994, shall be issued in accordance with these rules.

EXHIBIT A

...

CLAIMS PROVISIONS

...

PAYMENT OF CLAIMS

...

f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Policy to such provider.

...

DEFINITIONS

...

Experimental or Investigational means [Carrier] determines a service or supply is:

...

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

...

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

Reasonable and Customary means an amount that is not more than the [lesser of:

- the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
- the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

...

EMPLOYEE COVERAGE

...

[The Waiting Period

This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed

at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

...

COVERED CHARGES

...

Extended Care or Rehabilitation Charges

...

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. start within 14 days of a Hospital stay; and

b. be due to the same or a related condition that necessitated the Hospital stay.

...

COVERED CHARGES WITH SPECIAL LIMITATIONS

...

Therapy Services

...

f. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, *combined,* is limited to 30 visits per Calendar Year.

g. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

...

PREVENTIVE CARE

...

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or

b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the *Utilization Review Features* section for details.]

[This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the *Alternate Treatment Features* section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the *Centers of Excellence Features* section for details.]

[What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;

b. the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and

c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of this Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;

b. the named attending Practitioner; and

c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;

b. he or she changes attending Practitioners; or

c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;

b. the Covered Person group plan number;

c. the reason for the admission;

d. the name and location of the Hospital;

e. when the admission occurred; and

f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and

b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges, *by 50%*] if:

a. the Covered Person does not request a pre-hospital review; or

b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or

c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or

d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges *by 50%*], if:

a. [ABC] is not notified of the admission at the times and in the manner described above;

b. the Covered Person does not request a continued stay review; or

c. the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends *by 50%* as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or

b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;

b. is not a business associate of the Covered Person's Practitioner; and

c. does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the *Required Pre-Hospital Review* section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery *by 50%*] if:

a. the Covered Person does not request a pre-surgical review; or

b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or

c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;

d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under this Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous or psychoneurotic disorders
m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
- [DEF]
- attending Practitioner;
- Covered Person;
- Covered Person's family, if any; and

d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]]

...

COORDINATION OF BENEFITS

...

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

...

d. programs or coverages required by law;
e. group or group-type hospital indemnity benefits which exceed $250.00 per day;
f. Group or group-type hospital indemnity benefits of $250.00 per day or less for which the Employer pays part of the premium; or
g. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits of $250.00 per day or less for which the Employee pays the entire premium; nor
d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

EXHIBIT F

...

CLAIMS PROVISIONS

...

PAYMENT OF CLAIMS

...

f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Policy to such provider.

...

DEFINITIONS

...

Experimental or Investigational means [Carrier] determines a service or supply is:

...

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA ap-

proval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

. . .

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

Reasonable and Customary means an amount that is not more than the [lesser of:

- the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
- the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

. . .

EMPLOYEE COVERAGE

. . .

[The Waiting Period

This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

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HEALTH BENEFITS INSURANCE

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Co-Insurance Cap

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Each Covered Person's Co-Insurance amounts are used to meet his or her own Co-Insurance Cap [and are combined with Co-Insurance amounts from other covered family members to meet the family's Co-Insurance Cap]. But, all amounts used to meet the cap must actually be paid by a Covered Person out of his or her own pocket.

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COVERED CHARGES

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Extended Care or Rehabilitation Charges

. . .

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. start within 14 days of a Hospital stay; and

b. be due to the same or a related condition that necessitated the Hospital stay.

. . .

Prescription Drugs

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does not cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental and Nervous Conditions and Substance Abuse section of this Policy.

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COVERED CHARGES WITH SPECIAL LIMITATIONS

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Transplant Benefits

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h. Autologous Bone Marrow and Associated High Dose Chemotherapy only for treatment of:

- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
  —SCID
  —WISCOT Alldrich
- Subject to [Carrier] Pre-Approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. *Charges in connection with such treatment of breast cancer which are not Pre-Approved by [Carrier] are Non-Covered Charges.*

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or

b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the *Utilization Review Features* section for details.]

[This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the *Alternate Treatment Features* section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the *Centers of Excellence Features* section for details.]

[What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;

b. the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and

c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of this Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;

b. the named attending Practitioner; and

c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;

b. he or she changes attending Practitioners; or

c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;

b. the Covered Person group plan number;

c. the reason for the admission;

d. the name and location of the Hospital;

e. when the admission occurred; and

f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and

b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges, *by 50%*] if:

a. the Covered Person does not request a pre-hospital review; or

b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or

c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or

d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges *by 50%*], if:

a. [ABC] is not notified of the admission at the times and in the manner described above;

b. the Covered Person does not request a continued stay review; or

c. the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends *by 50%* as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or

b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;

b. is not a business associate of the Covered Person's Practitioner; and

c. does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the *Required Pre-Hospital Review* section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery *by 50%*] if:

a. the Covered Person does not request a pre-surgical review; or

b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or

c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;

d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under this Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay

b. spinal cord Injury

c. severe burn over 20% or more of the body

d. multiple injuries due to an accident

e. premature birth

f. CVA or stroke

g. congenital defect which severely impairs a bodily function

h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure

i. terminal illness, with a prognosis of death within 6 months

j. Acquired Immune Deficiency Syndrome (AIDS)

k. chemical dependency

l. mental, nervous and psychoneurotic disorders

m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;

b. the Covered Person's attending Practitioner; and

c. [Carrier].

The Alternate Treatment Plan includes:

a. treatment plan objectives;

b. course of treatment to accomplish the stated objectives;

c. the responsibility of each of the following parties in implementing the plan:

- [DEF]
- attending Practitioner;
- Covered Person;
- Covered Person's family, if any; and

d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and

b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]]

...

COORDINATION OF BENEFITS

...

DEFINITIONS

...

"Plan" means any of the following that provide health expense benefits or services:

...

d. programs or coverages required by law;

e. group or group-type hospital indemnity benefits which exceed $250.00 per day;

f. group or group-type hospital indemnity benefits of $250.00 per day or less for which the Employer pays part of the premium; or

g. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. group or group-type hospital indemnity benefits of $250.00 per day or less for which the Employee pays the entire premium; nor

d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

EXHIBIT G

...

[Carrier]

HMO PLAN

SMALL GROUP HEALTH MAINTENANCE INSURANCE ORGANIZATION CONTRACT

...

III. DEFINITIONS

...

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We Determine are:

a. not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or

b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or

c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition, as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

I. The American Medical Association Drug Evaluations;

II. The American Hospital Formulary Service Drug Information; or

III. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

...

REASONABLE and CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We determined based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary under this Contract. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

...

IV. ELIGIBILITY

EMPLOYEE COVERAGE

. . .

[**The Waiting Period**

This Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Contract from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

. . .

When Dependent Coverage Ends:

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted *[policies]* ***contracts***.

V. COVERED SERVICES AND SUPPLIES

. . .

c. INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS. The following Services are covered when hospitalized by a Participating Provider upon prior written referral from a Member's Primary Care Physician, only at Participating Hospitals and Participating Providers (or at Non-participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval.

. . .

23. Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the Member is participating in a National Cancer Institute sponsored clinical trial.

. . .

VIII. COORDINATION OF BENEFITS AND SERVICES

COORDINATION OF BENEFITS *AND SERVICES*

Purpose Of This Provision

A Member may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by this Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange [or provide] with what another plan pays or provides. We do this so the Member does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;

b. group hospital or surgical plans, or other service or prepayment plans on a group basis;

c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;

d. programs or coverages required by law;

e. group or group-type hospital indemnity benefits which exceed $250.00 per day;

f. group or group-type hospital indemnity benefits of $250.00 per day or less which the Employer pays part of the premium;

g. Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. group or group-type hospital indemnity benefits of $250.00 per day or less; nor

d. any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a subscriber or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works

We apply this provision when a subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first or provides services, ignoring all other plans. The secondary plans than pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a. A plan that covers a person as a subscriber pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a subscriber whose birthday falls later in the Calendar Year pays second. The subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d. For a Dependent child of separated or divorced parents, the following governs which plans pays or provides services first when the person is a Dependent of a subscriber.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.

- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver

We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under this Contract when services are incurred as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:

a. this Contract;
b. PIP; or
c. OSAIC.

"Eligible Services" means that of service provided for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

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

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

Determination of primary or secondary coverage.

This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the *[policyholder's]* ***Contract Holder's*** plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits or provide services as if it were primary.

Services this Contract will provide if it is primary to PIP or OSAIC.

If this Contract is primary to PIP or OSAIC it will provide benefits for eligible expenses in accordance with its terms.

The rules of the COORDINATION OF BENEFITS AND SERVICES section of this Contract will apply if:

- the Member is insured or covered for services under more than one insurance plan; and
- such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.

If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the equivalent value of services if this Contract had been primary.

...

IX. CONTRACT HOLDER GENERAL PROVISIONS

...

INCONTESTABILITY OF THE CONTRACT

...

If this Contract replaces the contract of another insurer ***or carrier***, we may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from this Contract's Effective Date.

...

X. MEMBER GENERAL PROVISIONS

...

INCONTESTABILITY OF THE CONTRACT

...

If this Contract replaces the contract of another insurer ***or carrier***, we may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from this Contract's Effective Date.

...

XI. CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

...

The Qualified Continuee's Responsibilities

...

b. the loss of dependent eligibility, as defined in this Contract, of {an insured} ***a covered*** Dependent child.

...

Election of Continuation

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed {insured} ***covered*** under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

...

When Continuation Ends

...

c. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of {an insured} ***a covered*** Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

...

When Continuation Ends

. . .

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual {insurance policy} ***contract***. Read this Contract's Conversion Rights for Divorced Spouses section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If an Employee's Group Benefits End

If an Employee's health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then {insured} ***covered*** Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

. . .

What The Employee Must Do

. . .

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed {insured} ***covered*** under this Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been {insured} ***covered*** by this Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, hsi or her then {insured} ***covered*** Dependents.

. . .

How And When To Continue Coverage

. . .

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, {insured} ***covered*** under this Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

. . .

If An Employee's Group Health Coverage Ends

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' {insurance} ***coverage*** may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

{Insurance} ***Coverage*** may continue until the earliest of:

a. the date the Employee returns to Full-Time work

b. the end of a total period of 12 weeks in any 12 month period, or

c. the date on which the Employee's coverage would have ended had the Employee not been on leave.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were {insured} ***covered*** under this contract may elect to continue coverage. Subject to the payment of the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of the Employee's death; or

b. the date the Dependent is no longer eligible under the terms of this Contract.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual {policy} ***contract*** during the conversion period. The former spouse may {insure} ***cover*** under his or her individual {policy} ***contract*** any of his or her Dependent children who were {insured} ***covered*** under this Contract on the date the group health benefits ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

- unless he or she has been {insuraced} ***covered*** under this Contract for at least 3 months;
- if he or she is eligible for Medicare;
- if it would cause him or her to be {overinsured} ***excessively covered***; or
- [if he or she permanently relocates outside the Service Area.]

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will determine if {overinsurance} ***excessive coverage*** exists using Our standards for {overinsurance} ***excessive coverage***.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual {policy} ***contract*** in writing and pay the first premium for such {policy} ***contract*** during the conversion period. Evidence of {insurability} ***good health*** will not be required.

THE CONVERTED POLICY

The individual {policy} ***contract*** will provide the medical benefits that We are required to offer. The individual {policy} ***contract*** will take effect on the day after group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual {policy} ***contract*** may still {be paid} ***receive*** benefits under this Contract. If so, benefits to be paid under the individual {policy} ***contract, if any,*** will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.

XII. RIGHT TO RECOVER—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, {insured} ***covered*** by this Contract.

. . .

EXHIBIT H
PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD/MAIL)

. . .

The Prescription Drug section of the COVERED CHARGES provision of the HEALTH BENEFITS INSURANCE section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's

and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

...

DEFINITIONS

...

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

...

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is *not* obtained through the Mail Order Program is:

...

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);

b. dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and

c. needed to treat an Illness or Injury or Mental and Nervous Conditions and Substance Abuse.

Such changes will not include charges made for more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;

b. a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and

c. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

...

EXHIBIT H
PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD)

...

The Prescription Drug section of the COVERED CHARGES provision of the HEALTH BENEFITS INSURANCE section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

...

EXHIBIT H
PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE (MAIL)

...

The Prescription Drug section of the COVERED CHARGES provision of the HEALTH BENEFITS INSURANCE section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

...

DEFINITIONS

...

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

...

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs NONE
- for Brand Name Drugs $5.00

...

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

...

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);

b. dispensed by a Participating Mail Order Pharmacy for take-home use; and

c. needed to treat an Illness or Injury or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug; and

b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

...

EXHIBIT I

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

Policyholder:

Group Policy No.:

Effective Date:

The Prescription Drug section of the COVERED CHARGES provision of the HEALTH BENEFITS INSURANCE section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, or Mental and Nervous Conditions and Substance Abuse which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness, Injury or Mental and Nervous Conditions and Substance Abuse by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

...

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

a. the Covered Person does not request a review in the times and manner described above;

...

EXHIBIT K
PART 1

EXPLANATION OF BRACKETS—POLICY FORMS

(PLANS A, B, C, D, E)

...

Areas of variability which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in the policy forms.

...

5. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.

6. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.

7. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.

8. The Waiting Period provision of the Employee Coverage provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.

9. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.

10. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, either the text must conform to the text of the standard form, except that the penalty for non-compliance may be adjusted to reflect a different percentage, or

to utilize a dollar penalty; or the text must be submitted to the Board and the Department of Insurance for review and approval prior to use, as specified in regulation.

11. The Alternate Treatment Features provisions may be omitted. Carrier may administratively provide for such provisions. If included in the policy, the text must conform to the text of the standard form.

12. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.

...

EXHIBIT K
PART 2

EXPLANATION OF BRACKETS (HMO PLAN)

...

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract forms.

...

7. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.

...

Full text of the proposed new exhibits follows:

EXHIBIT V

[Carrier] **PLAN A**

SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

[[Carrier] certifies that the Employee named [below] is entitled to the benefits described in this [certificate], as of the effective date shown [below], subject to the eligibility and effective date requirements of the Policy.

This [certificate] replaces any and all [certificates] previously issued to the Employee under any group policies issued by [Carrier] providing the types of benefits described in this [certificate].

The Policy is a contract between [Carrier] and the Policyholder. This [certificate] is a summary of the Policy provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Policy.

POLICYHOLDER:	[ABC Company]
GROUP POLICY NUMBER:	[G-12345]
EMPLOYEE:	[JOHN DOE]
CERTIFICATE NUMBER:	[C-1234567]
EFFECTIVE DATE:	01-01-94

[CERTIFICATE] INDEX

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SCHEDULE OF INSURANCE **PLAN A**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible:

• for Hospital Confinement	None (Note: See Hospital Confinement Co-Payment)
• for Preventive Care	None
• for All Other Charges	
—per Covered Person	$250
—per Covered Family	$500 Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have
paid had the Covered Person been so insured.

After the 18 month period described in Medicare as Secondary Payor, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$250
—maximum Co-Payment per Period of Confinement	$1,250
—maximum Co-Payment per Covered Person per Calendar Year	$2,500

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:

• for Preventive Care	None
• for Facility charges made by:	
—a Hospital	20%
—an Ambulatory Surgical Center	20%
—a Birthing Center	20%
—an Extended Care Center or Rehabilitation Center	20%
—a Hospice	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:	
—Prescription Drugs	20%
—Blood Transfusions	20%
—Infusion Therapy	20%
—Chemotherapy	20%
—Radiation Therapy	20%
• for all other Covered Charges	50%
Co-Insurance Cap per Covered Person per each Calendar Year	$5,000

Daily Room and Board Limits

• During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable disease, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:
a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible:

• for Hospital Confinement	None (Note: See Hospital Confinement Co-Payment)
• for Preventive Care	None
• for All Other Charges	
—per Covered Person	$250
—per Covered Family	$500 Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in Medicare as Secondary Payor, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$250
—maximum Co-Payment per Period of Confinement	$1,250
—maximum Co-Payment per Covered Person per Calendar Year	$2,500

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

	If treatment, services or supplies are given by:	
	a Network Provider	*an Out-Network Provider*
The Co-Insurance for the Policy is as follows:		
• for Preventive Care	None	None
• for Facility charges made by:		
—a Hospital	None	20%
—an Ambulatory Surgical Center	None	20%
—a Birthing Center	None	20%
—an Extended Care Center or Rehabilitation Center	None	20%
—a Hospice	None	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
—Prescription Drugs	None	20%
—Blood Transfusions	None	20%
—Infusion Therapy	None	20%
—Chemotherapy	None	20%
—Radiation Therapy	None	20%
• for all other Covered Charges	70%	50%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required.

Coinsured Charge Limit: $10,000

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:
a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient Hospital confinement	30 days
Charges for Home Health Care	exchange basis * for Hospital days
Charges for Extended Care or Rehabilitation Center Care	exchange basis * for Hospital days
Charges for Hospice Care	exchange basis * for Hospital days

*See the **Covered Charges** section for a description of the exchange rules.

Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance)	
—per Covered Person	$100
—per Covered Family	$300
Per Lifetime Maximum Benefit (for all Illnesses and Injuries	$1,000,000

GENERAL PROVISIONS

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under the Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

[PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of the Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time the Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.]

MISSTATEMENTS

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], or the amount of coverage, subject to the Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Policy, and in what amounts.

[DIVIDENDS

[Carrier] will determine the share, if any, of its divisible surplus allocable to the Policy as of each Policy Anniversary, if the Policy stays in force by the payment of all premiums to that date. The share will be credited to the Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under the Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under the Policy.

CONFORMITY WITH LAW

Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION

The health benefits provided under the Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by the Policy is governed as follows:

[NOTICE OF LOSS

A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Policy to such provider.

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

A Covered Person cannot bring a legal action against the Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against the Policy after three years from the date he or she files proof of loss.

DEFINITIONS

The words shown below have special meanings when used in the Policy and this [certificate]. Please read these definitions carefully. [Throughout the [certificate], these defined terms appear with their initial letter capitalized.]

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.

Alcohol Abuse means abuse of or addiction to alcohol.

Ambulance means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before the Policy pays any benefits for such charges. Cash Deductible does not include Co-Insurance, Co-Payments and Non-Covered Charges. See the **The Cash Deductible** section of this [certificate] for details.

Co-Insurance means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does not include Cash Deductibles, Co-Payments or Non-Covered Charges.

Co-Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and

b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Covered Person means an eligible Employee or a Dependent who is insured under the Policy.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or

b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

Dependent means Your:

a. legal spouse;

b. unmarried Dependent child who is under age 19; and

c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or

b. eligible for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this [certificate].

An Employee's "unmarried Dependent child" includes:

a. Your legally adopted children,

b. Your step-children if such step-children depend on You for most of their support and maintenance, and

c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purposes of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Dependent's Eligiblity Date means the later of:

a. the Employee's Eligiblity Date; or

b. the date the person first becomes a Dependent.

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

a. radiology, ultrasound and nuclear medicine;

b. laboratory and pathology; and

c. EKG's, EEG's and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:

a. designed and able to withstand repeated use;

b. primarily and customarily used to serve a medical purpose;

c. generally not useful to a Covered Person in the absence of an Illness or Injury; and

d. suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date coverage begins under the Policy for an Employee or Dependent.

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Policy's conditions of eligibility. Employees who work on a temporary or substitute basis are not considered to be Employees for the purpose of the Policy. See also You, Your, Yours.

Employee's Eligiblity Date means the later of:

a. the date of employment; or

b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or

b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or

c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;

2. The American Hospital Formulary Service Drug Information; or

3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the

drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or

b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is required by law to recognize which:

a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by the Policy.

Full-Time means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or

b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission; or

b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

Initial Dependent means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

Injury means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized heath care Facility.

Joint Commission means the Joint Commission on the Accreditation of Health Care Facilities.

Late Enrollee means an eligible Employee or Dependent who requests enrollment under the Policy more than [30] days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and Dependent Coverage sections of the Policy.

Medical Emergency means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;

b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;

c. in accordance with generally accepted medical practice;

d. not for the convenience of a Covered Person;

e. the most appropriate level of medical care the Covered Person needs;

f. furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

Mental and Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods of psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behaviorial abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

Non-Covered Charges are charges which do not meet the Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in the Policy and in this [certificate], or which are specifically identified as Non-Covered Charges or are otherwise not covered by the Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under the Policy or any other policy or plan:

a. as an Employee or Dependent; and

b. with or without interruption.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by Your Employer. [Note: If the "Plan" definition is employed, references in this [certificate] to "Policy" should be changed to read "Plan"]

Planholder means Your Employer who purchased this group health benefit plan. [Note: If the "Planholder" definition is employed, references in this [certificate] to "Policyholder" should be changed to read "Planholder"]

Podiatric Care means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

Policy means the group policy, including the application and any riders, amendments, or endorsements, between Your Employer and [Carrier].

Policyholder means Your Employer who purchased the Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of the Policy.

Reasonable and Customary means an amount that is not more than the [lesser of:

- the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
- the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under the Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

b. approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the Schedule of Insurance contained in the Policy and in this [certificate].

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Center (see Extended Care Center.)

Small Employer means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a. intensive care units;

b. cardiac care units;

c. neonatal care units; and

d. burn units.

Substance Abuse means abuse of or addiction to drugs.

Surgery means:

a. the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

b. the correction of fractures and dislocations;

c. Reasonable and Customary pre-operative and post-operative care; or

d. any of the procedures designated by Current Procedural Terminology codes as Surgery.

Therapeutic Manipulation means the treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydro therapy or other treatment of similar nature.

Total Disability or Totally Disabled means, except as otherwise specified in the Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

[**We, Us, Our** and [**Carrier**] mean [Carrier].]

[**You, Your and Yours** mean an Employee who is insured under the Policy.]

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of the Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not insure an Employee unless the Employee is an Actively at Work Full-Time Employee.

Enrollment Requirement

[Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:

a. more than [30] days after the Employee's Eligibility Date; or

b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to the Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under the Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under the Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;

b. divorce;

c. death of the Employee's spouse; or

d. termination of the other plan's coverage.

But, the Employee must enroll under the Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

The Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under the Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under the Policy from the date after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under the Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

When Employee Coverage Starts

You must be Actively at Work, and working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. If You are not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of Your Coverage until You return to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.

You must elect to enroll and agree to make the required payments, if any, within [30] days of the Employee's Eligibility Date. If You do this within [30] days of the Employee's Eligibility Date, Your coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the scheduled Effective Date of Your coverage.

When Employee Coverage Ends

Your insurance under the Policy will end on the first of the following dates:

a. [the date] You cease to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, layoff, leave of absence, and the end of employment.

b. [the date] You stop being an eligible Employee under the Policy.

c. the date the Policy ends, or is discontinued for a class of Employees to which You belong.

d. the last day of the period for which required payments are made for You.

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This [certificate's] benefits provisions explain these situations. Read this [certificate's] provisions carefully.

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

Your eligible Dependents are Your:

a. legal spouse;

b. unmarried Dependent children who are under age 19; and

c. unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or

b. eligible for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this [certificate].

Your "unmarried Dependent child" includes:

a. Your legally adopted children,

b. Your step-children if such step-children depend on You for most of their support and maintenance, and

c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

You may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Policy, such a child may stay eligible for Dependent health benefits past the Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached the Policy's age limit;

b. the child became insured by the Policy or any other policy before the child reached the age limit and stayed continuously insured after reaching such limit; and

c. the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send [Carrier] written proof that the child is incapacitated and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when Your coverage does.

Enrollment Requirement

You must enroll Your eligible dependents in order for them to be covered under the Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:

a. enroll a Dependent and agree to make the required payments more than [30] days after the Dependent's Eligibility Date;

b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who You have not elected to enroll; or

c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to the Policy's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

However, if You previously waived coverage for Your spouse or eligible Dependent children under the Policy and stated at that time that such waiver was because they were covered under another group plan, and You now elect to enroll them in the Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of Your spouse; or
d. termination of the other plan's coverage.

But, You must enroll Your spouse or eligible Dependent children within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Policy, to be a Late Enrollee, if:

a. You are under legal obligation to provide coverage due to a court order; and

b. You enroll Your spouse or eligible Dependent children within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

When Dependent Coverage Starts

In order for Your dependent coverage to begin You must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the exception stated below and to all of the terms of the Policy, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. The Dependent's Eligibility Date, or
b. the date You become insured for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a. the date You sign the enrollment form; or
b. the date You become insured for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify [Carrier] of a Newly Acquired Dependent within [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:

a. the date You notify [Carrier] and agree to make any additional payments, or

b. the Dependent's Eligbility Date for the Newly Acquired Dependent.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date Your Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

Newborn Children

[Carrier] will cover Your newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:

a. If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.

b. If You are not covered for Dependent child coverage on the date the child is born, then You must:

- make written request to enroll the newborn child; and
- pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's insurance under the Policy will end on the first of the following dates:

a. [the date] Your coverage ends;

b. the date You stop being a member of a class of Employees eligible for such coverage;

c. the date the Policy ends;

d. the date Dependent coverage is terminated from the Policy for all Employees or for Your class;

e. the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons;

f. at 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read this [certificate] carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer, XYZ Health Care Network, and the [Carrier]

The Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by the Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

The Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of the Policy. You should read Your [certificate] carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If You have any questions after reading Your [certificate], You should call [Carrier] [Group Claim Office at the number shown on Your identification card.]

[**Note:** Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions

a. *Primary Care Practitioner* (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.

b. *Provider Organization* (PO) means a network of health care Providers located in a Covered Person's Service Area.

c. *Network Benefits* mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.

d. *Out-Network Benefits* mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.

e. *Service Area* means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for the Policy is the [XYZ] Provider Organization. The Policy requires that the Covered Person uses the services

of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care Practitioner (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-Network Benefits.

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, the Covered Person may only be eligible for Out-Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

Out-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out-Network Benefits.

Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. [Carrier] will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

Utilization Review

The Policy has utilization features. See the **Utilization Review Features** section of this [certificate].

Benefits

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of the Policy.

[**Note:** Used only if coverage is issued as POS.]

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in the Policy and in this [certificate].

BENEFIT PROVISION

The Cash Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by the Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by the Policy. And what [Carrier] pays is based on all the terms of the Policy.

Family Deductible Limit

The Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of the Policy.

Co-Insurance Cap

The Policy limits Co-Insuance amounts each Calendar Year except as stated below. The Co-Insurance Cap cannot be met with:

a. Non-Covered Charges;
b. Cash Deductibles; and
c. Co-Payments.

There is Co-Insurance Cap for each Covered Person.

The Co-Insurance Cap is shown in the Schedule.

Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans

The benefits [Carrier] will pay may be affected by a Covered Person being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan

The Employer who purchased the Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet the Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which the Policy starts;
b. The Policy would have paid benefits for the charges, if the Policy had been in effect;
c. The Covered Person was covered by the old plan when it ended and enrolled in the Policy on its Effective Date; and
d. The Policy starts right after the old plan ends.

Extended Health Benefits

If the Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under the Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of the Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends; or

b. one year from the date the person's insurance under the Policy ends; or

c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Charges while Hospitalized

[Carrier] covers charges incurred while a Covered Person is an Inpatient in a Hospital up to 30 days per Covered Person per Calendar Year. Covered Charges are as follows:

a. Hospital room and board

b. Routine Nursing Care

c. Prescription Drugs

d. Blood transfusions

e. Infusion Therapy

f. Chemotherapy

g. Radiation Therapy

h. Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

[Carrier] limits what it pays for each day to the room and board limit shown in the Schedule.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

Note: [Carrier] covers charges for Inpatient Hospital care up to 30 days per Covered Person per Calendar Year. Such 30 Inpatient days may be exchanged for other types of care, as explained in the **Extended Care or Rehabilitation Charges, Home Health Care Charges** and **Hospice Charges** sections.

Hospital Co-Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Co-Payment for each day of confinement, up to a maximum of $1,250 per Period of Confinement, subject to a maximum $2,500 Co-Payment per Calendar Year.

Testing Charges

[Carrier] covers x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred soley due to a change in the Covered Person's health.

X-ray and laboratory tests which are not performed in connection with a planned Hospital admission or Surgery are Non-Covered Charges.

Extended Care or Rehabilitation Charges

Subject to [Carrier's] Pre-Approval, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, [Carrier] covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement, but the confinement must:

a. start within 14 days of a Hospital stay; and

b. be due to the same or a related condition that necessitated the Hospital stay.

Extended Care or Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges:

Subject to [Carrier's] Pre-Approval, when Home Health Care can take the place of Inpatient Hospital care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a registered Nurse);

b. physical therapy;

c. occupational therapy;

d. medical social work;

e. nutrition services;

f. speech therapy;

g. home health aide services;

h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and

i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:

a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.

b. The services and supplies must be:

- ordered by the Covered Person's Practitioner;
- included in the home health care plan; and
- furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.

d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

e. [Carrier] does not pay for:

- services furnished to family members, other than the patient; or
- services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury which are incurred while the Covered Person is an Inpatient in a Hospital.

Practitioner's Charges for Surgery

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

Second Opinion Charges

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;

b. are not business associates of the Practitioner who recommended the Surgery; and

c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Ambulatory Surgical Center Charges

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospital Care Charges

Subject to [Carrier] Pre-Approval, when Hospice Care can take the place of Inpatient Hospital Care, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered Person under a Hospice care program. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal illness or terminal injury.

"Terminally ill" or "terminally injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of the Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a. needed for palliative and supportive care;
b. ordered by the Covered Person's Practitioner;
c. included in the Hospice care program; and
d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:

a. services and supplies provided by volunteers or others who do not regularly charge for their services;
b. funeral services and arrangements;
c. legal or financial counseling or services; or
d. treatment not included in the Hospice care plan.

Hospital Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Pregnancy

The Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges

[Carrier] covers Birthing Center charges made by a Practitioner for prenatal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a. nursery charges;
b. charges for routine Practitioner's examinations and tests; and
c. charges for routine procedures, like circumcision.

Subject to all of the terms of the Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

Anesthetics

[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Policy. See this [certificate's] **EMPLOYEE COVERAGE** and **DEPENDENT COVERAGE** sections to determine if a Covered Person is a Late Enrollee. The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.

Pre-Existing Conditions

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions until the Covered Person has been continuously covered by the Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a Covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in the Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under the Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under the Policy starts. If the Employer has included an eligibility waiting period in the Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] only covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below when provided on either an Inpatient or on an Outpatient basis.

a. *Chemotherapy*—the treatment of malignant disease by chemical or biological antineoplastic agents.

b. *Radiation Therapy*—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

[Carrier] covers the Therapy Services listed below but only when provided on an Inpatient basis.

c. *Chelation Therapy*—means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

d. *Respiration Therapy*—the introduction of dry or moist gases into the lungs.

e. *Cognitive Rehabilitation Therapy*—the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.

f. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, combined, is limited to 30 visits per Calendar Year.

g. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

h. *Physical Therapy*—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss or limb.

Coverage for Occupational Therapy and Physical Therapy, combined, is limited to 30 visits per Calendar Year.

i. *Infusion Therapy*—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person, $300 per Covered Family.

IMPORTANT NOTICE

[The Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or

b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under the Policy. See the **Utilization Review Features** section for details.]

[The Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[The Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.]

[What [Carrier] pays is subject to all of the terms of the Policy. Read this [certificate] carefully and keep it available when consulting a Practitioner.

If You have any questions after reading this [certificate] You should [call The Group Claim Office at the number shown on Your identification card.]

The Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with the Policy's utilization review features, he or she will not be eligible for full benefits under the Policy.

Compliance with the Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;

b. the Covered Person being eligible for coverage under the Policy at the time the Covered Charges are incurred; and

c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of the Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Policy is not payable under the Policy.

"Regular working day" means [Monday through Friday from 9 A.M. to 9 P.M. Eastern Time,] not including legal holidays.

Grievance Procedure

[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;

b. the named attending Practitioner; and

c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;

b. he or she changes attending Practitioners; or

c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;

b. the Covered Person group plan number;
c. the reason for the admission;
d. the name and location of the Hospital;
e. when the admission occurred; and
f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of their review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%] if:

a. the Covered Person does not request a pre-hospital review; or
b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%] if:

a. [ABC] is not notified of the admission at the times and in the manner described above;
b. the Covered Person does not request a continued stay review; or
c. the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends by 50% as a penalty for non-compliance.

Penalties cannot be used to meet the Policy's:
a. Cash Deductible; or
b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or
b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under the Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b. is not a business associate of the Covered Person's Practitioner; and
c. does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of the Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the Proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery by 50%] if:

a. the Covered Person does not request a pre-surgical review; or
b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done; or
d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Policy's:
a. Cash Deductible; or
b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function

h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes:
a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
- [DEF]
- attending Practitioner
- Covered Person
- Covered Person's family, if any; and

d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:
a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the Utilization Review Features will not apply.]]

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of *acupuncture* except when used as a substitute for other forms of anesthesia.

Care or treatment of *alcohol abuse.*

Services for *ambulance* for transportation.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a *Christian Science* Practitioner.

Completion of claim forms.

Services or supplies related to *cosmetic surgery,* except as otherwise stated in the Policy, unless it is required as a result of an Illness or Injury sustained while covered under the Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to *custodial* or *domiciliary* care.

Dental care or treatment, including appliances.

Charges made by a *dialysis center* for dialysis services.

Durable Medical Equipment

Services or supplies, the primary purpose of which is *educational* providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Care or treatment in an *emergency room* unless the Covered Person is admitted within 24 hours.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a. exams to determine the need for (or changes of) *eyeglasses* or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's *family:* spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance *fertility* using artificial and surgical drugs and procedures, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to *Hearing aids and hearing exams* to determine the need for hearing aids or the need to adjust them.

Services or supplies related to *Herbal medicine.*

Care or treatment by means of *high dose chemotherapy.*

Services or supplies related to *Hypnotism.*

Services or supplies because the Covered Person engaged, or tried to engage, in an *illegal occupation* or committed or tried to commit a felony.

Illness or *Injury,* including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Care and treatment for *Mental and Nervous Conditions and Substance Abuse.*

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to *Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.*

Supplies related to *Methadone* maintenance.

Any charge identified as a *Non-Covered Charge* or which are specifically limited or excluded elsewhere in the Policy and this [certificate], or which are not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except insulin needles and syringes.

Services provided by a licensed *pastoral counselor* in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Podiatric care

Practitioner visits, except as otherwise stated in the Policy.

Prescription Drugs obtained while not confined in a Hospital on an Inpatient basis.

Services or supplies that are not furnished by an eligible *Provider.*

Services related to *Private-Duty Nursing care,* except as provided under the Home Health Care section of this [certificate].

Prosthetic Devices

The amount of any charge which is greater than a *Reasonable and Customary Charge.*

Services or supplies related to *rest or convalescent cures.*

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, *Routine examinations* or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to *Routine Foot Care.*

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a *social worker,* except as otherwise stated in the Policy.

Services or supplies:

a. eligible for payment under either Federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;

b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

c. for which a Covered Person would not have been charged if he or she did not have health care coverage;

d. provided by or in a government Hospital unless the services are for treatment:

- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Stand-by services required by a Provider.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Therapeutic Manipulation.

Transplants.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a *war,* declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this [certificate's] COBRA CONTINUATION RIGHTS (CCR) section and under other continuation sections of this [certificate] at the same time.

Continuation Under CCR and NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this [certificate's] CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this [certificate]:

If a Covered Person elects to continue his or her group health benefits under both this [certificate's] CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following **COBRA CONTINUATION RIGHTS** section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

a. Your Employer is subject to the **COBRA CONTINUATION RIGHTS** section in which case;
b. the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Policy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under the Policy during a continuation provided by this section is not qualified continuee.

If An Employee's Group Health Benefits Ends

If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:

a. You were not terminated due to gross misconduct; and
b. You are not entitled to Medicare.

The continuation:

a. may cover You and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours, You may elect to extend Your 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the United States Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If You die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Policy, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group benefits due to any of the reasons stated above; or

b. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or

b. the loss of dependent eligibility, as defined in the Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue the Policy's group health benefits;

b. the monthly premium he or she must pay to continue such benefits; and

c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or

b. the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of [Carrier], if:

a. The Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or

b. The Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d. with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

e. the date the Policy ends;

f. the end of the period for which the last premium payment is made;

g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;

h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this [certificate's] **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If an Employee's Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What the Employee Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed insured under the Policy on a regular basis. It includes any amount that Your Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under the Policy on a regular basis. Any modifications made under the Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for You to continue.

When Continuation Ends

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;

b. the date the Covered Person becomes eligible for Medicare;

c. the end of the period for which the last premium payment is made;

d. the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-existing Condition of the Covered Person;

e. with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;

f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or

g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been insured by the Policy for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, You must give Your Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, insured under the Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay [Carrier] on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if You stop paying.

b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan.

c. the date the Policy ends or is amended to end for the class of Employees to which You belonged; or

d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

- Your Employer must allow for a leave of absence under Federal law in which case;
- the section applies to You.

If An Employee's Group Health Coverage Ends

Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your group health benefits insurance will be continued. Dependents' insurance may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date You return to Full-Time work;

b. the end of a total leave period of 12 weeks in any 12 month period;

c. the date on which Your coverage would have ended had You not been on leave; or

d. the end of the period for which the premium has been paid.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were insured under the Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of Your death; or

b. the date the Dependent is no longer eligible under the terms of the Policy.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health benefits for Your former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under the Policy on the date the group health benefits ends. See **exceptions** below.

Exceptions

No former spouse may use this conversion right:

a. if he or she is eligible for Medicare; or

b. if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under the Policy ends.

After group health benefits under the Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under the Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under the Policy.

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by the Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends

Insurance for You and Your Dependents will end on the date You become an HMO member.

Benefits After Group Health Benefits Insurance Ends

When You become an HMO member, the **Extended Health Benefits** section of this [certificate] will not apply to You and Your Dependents.

Exception:

IF, on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing Conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for total disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre-Existing Conditions limit expires, or
- hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THE POLICY

Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If You elect to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period

[Carrier] and the Policyholder will agree when this period will be. If You request insurance during this period, You and Your Dependents will be insured on the date such period ends.

request made because:

- an HMO ends its operations
- Employee moves outside the HMO service area

If You request insurance because membership ends for these reasons, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made because an HMO becomes insolvent

If You request insurance because membership ends for this reason, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:

- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made at any other time

You may request insurance at any time other than that described above. In this case, You and Your Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by the Policy for such insurance, will not apply on the transfer date:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre-Existing Conditions provisions.

Charges not covered

Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit

The total amount of benefits to be paid for each person will be the maximum benefit specified in the Policy, regardless of an interruption in such person's insurance under the Policy.

Right to change premium rates

[Carrier] has the right to change premium rates when, in its opinion, its liability under the Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;

b. group hospital or surgical plans, or other service or prepayment plans on a group basis;

c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;

d. programs or coverages required by law;

e. group or group-type hospital indemnity benefits which exceed $250.00 per day;

f. group or group-type hospital indemnity benefits of $250.00 per day or less for which You pay part of the premium; or

g. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. group or group-type hospital indemnity benefits of $250.00 per day or less for which You pay the entire premium; nor

d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pays less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information

In order to coordinate benefits, [Carrier] needs certain information. You must supply [Carrier] with as much of that information as You can. But if You cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan has been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under the Policy when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or

b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. the Policy;

b. PIP; or

c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

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

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

Determination of primary or secondary coverage

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

The Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case the Policy will be primary.

If there is a dispute as to which policy is primary, the Policy will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.

If the Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of the Policy will apply if:

- the covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.

If the Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or

b. the benefits that would have been paid if the Policy had been primary.

Medicare

If the Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

Important Notice

The following sections regarding Medicare may not apply to Your Employer's Policy. You must contact Your Employer to find out if Your Employer is subject to Medicare as Secondary Payor rules.

If Your Employer is subject to such rules, this Medicare as Secondary Payor section applies to You.

If Your Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to You, in which case, Medicare will be the primary health plan and the Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how the Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the United States Social Security Act, as amended from time to time.

b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.

c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".

[d. "We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to You or Your insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse

b. an Employee or insured spouse who is under age 65, or

c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A)—The Medicare eligible may choose the Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When the Policy is Primary** section below, for details.

Option (B)—The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When the Policy is primary

When a Medicare eligible chooses the Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Policy. Coverage under the Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a Covered Person who is:

a. under age 65; and

b. eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or

b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When a Covered Person Becomes Eligible For Medicare

When a Covered Person becomes eligible for Medicare by reason of disability, Medicare is the primary plan. The Policy is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and

b. with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by the Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under the Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;

b. a satisfied judgment; or

c. other means.

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or

b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under the Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.

b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a Federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a Federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.

b. If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.

c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:

- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

EXHIBIT W

[Carrier] **PLANS B, C, D, E**

SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

[[Carrier] certifies that the Employee named [below] is entitled to the benefits described in this [certificate], as of the effective date shown [below], subject to the eligibility and effective date requirements of the Policy.

This [certificate] replaces any and all [certificates] previously issued to the Employee under any group policies issued by [Carrier] providing the types of benefits described in this [certificate].

The Policy is a contract between [Carrier] and the Policyholder. This [certificate] is a summary of the Policy provisions that affect Your insurance. All benefits and exclusions are subject to the terms of the Policy.

POLICYHOLDER:	[ABC Company]
GROUP POLICY NUMBER:	[G-12345]
EMPLOYEE:	[JOHN DOE]
CERTIFICATE NUMBER:	[C-1234567]
EFFECTIVE DATE:	01-01-94
CALENDAR YEAR CASH DEDUCTIBLE	
PER COVERED PERSON:	$250
PER COVERED FAMILY:	$500
COINSURANCE:	20%
COINSURANCE CAPS	
PER COVERED PERSON:	$2,000
PER COVERED FAMILY:	$4,000]

[Secretary President]

[Dividends are apportioned each year.]

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SCHEDULE OF INSURANCE [PLAN B]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$200
—maximum Co-Payment per Period of Confinement	$1,000
—maximum Co-Payment per Covered Person per Calendar Year	$2,000
Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:	40%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$3,000
Per Covered Family per each Calendar Year	$6,000, **Note:** Must be individually satisfied by 2 separate Covered Persons

Note: The Co-Insurance Caps cannot be met with:
- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments

SCHEDULE OF INSURANCE [PLAN C]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:	30%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$2,500
Per Covered Family per each Calendar Year	$5,000, **Note:** Must be individually satisfied by 2 separate Covered Persons

Note: The Co-Insurance Caps cannot be met with:
- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments.

SCHEDULE OF INSURANCE [PLAN D]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:	20%, **except as stated below**
Exception: for Mental and Nervous and Substance Abuse charges	25%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$2,000
Per Covered Family per each Calendar Year	$4,000, **Note:** Must be individually satisfied by 2 separate Covered Persons

Note: The Co-Insurance Caps cannot be met with:
- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments.

SCHEDULE OF INSURANCE [PLAN E]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	$150
Per Covered Family	$300, **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:	10%, **except as stated below**
Exception: for Mental and Nervous and Substance Abuse charges	25%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$1,500
Per Covered Family per each Calendar Year	$3,000, **Note:** Must be individually satisfied by 2 separate Covered Persons

Note: The Co-Insurance Caps cannot be met with:
- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments.

SCHEDULE OF INSURANCE EXAMPLE PPO (without Co-Payment)

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment	
—per day	$200
—maximum Co-Payment per Period of Confinement	$1,000
—maximum Co-Payment per Covered Person per Calendar Year	$2,000
Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:

• if treatment, services or supplies are given by a Network Provider	20%
• if treatment, services or supplies are given by an Out-Network Provider	40%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit:	$10,000

SCHEDULE OF INSURANCE EXAMPLE PPO (with Co-Payment)

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Co-Payment—If treatment, services or supplies are given by a Network Provider:	
• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year

Calendar Year Cash Deductible— If treatment, services or supplies are given by an Out-Network Provider

Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) (Out-Network Provider)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:

• if treatment, services or supplies are given by a Network Provider	None
• if treatment, services or supplies are given by an Out-Network Provider	30%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit:	$10,000

SCHEDULE OF INSURANCE **EXAMPLE POS**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Co-Payment—If treatment, services or supplies are given or referred by a PCP:	
• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year

Calendar Year Cash Deductible—If treatment, services or supplies are given by a Non-referred Provider	
Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) (Out-Network Provider)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The Co-Insurance for the Policy is as follows:

• if treatment, services or supplies are given by the PCP	None, **except as stated below**
• if treatment, services or supplies are given or referred by a non-referred Provider	20%, **except as stated below**

Exception: for Mental and Nervous and Substance Abuse charges

• if treatment, services or supplies are given or referred by the PCP	5%
• if treatment, services or supplies are given by a non-referred Provider	25%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit:	$10,000

[PLAN B]

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits

Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person
• for all other Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries	$1,000,000

[PLANS C, D, E]

Daily Room and Board Limits

• During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

• During a Confinement In An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person
• for all other Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries	Unlimited

GENERAL PROVISIONS

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under the Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

[PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of the Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time the Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.]

MISSTATEMENTS

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], or the amount of coverage, subject to the Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Policy, and in what amounts.

[DIVIDENDS

[Carrier] will determine the share, if any, of its divisible surplus allocable to the Policy as of each Policy Anniversary, if the Policy stays in force by the payment of all premiums to that date. The share will be credited to the Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under the Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under the Policy.

CONFORMITY WITH LAW

Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION

The health benefits provided under the Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by the Policy is governed as follows:

[NOTICE OF LOSS

A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Policy to such provider.

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

A Covered Person cannot bring a legal action against the Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against the Policy after three years from the date he or she files proof of loss.

DEFINITIONS

The words shown below have special meanings when used in the Policy and this [certificate]. Please read these definitions carefully. [Throughout this [certificate], these defined terms appear with their initial letter capitalized.]

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.

Alcohol Abuse means abuse of or addiction to alcohol.

Ambulance means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before the Policy pays any benefits for such charges. Cash Deductible does not include Co-Insurance, Co-Payments and Non-Covered Charges. See the **The Cash Deductible** section of this [certificate] for details.

Co-Insurance means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does **not** include Cash Deductibles, Co-Payments or Non-Covered Charges.

Co-Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and
b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Covered Person means an eligible Employee or a Dependent who is insured under the Policy.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

Dependent means Your:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.

A Dependent is not a person who is:
a. on active duty in any armed forces of any country; or
b. eligible for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this [certificate].

An Employee's "unmarried Dependent child" includes:
a. Your legally adopted children,
b. Your step-children if such step children depend on You for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purposes of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Dependent's Eligiblity Date means the later of:
a. the Employee's Eligiblity Date; or
b. the date the person first becomes a Dependent.

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:
a. designed and able to withstand repeated use;
b. primarily and customarily used to serve a medical purpose;
c. generally not useful to a Covered Person in the absence of an Illness or Injury; and
d. suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date coverage begins under the Policy for an Employee or Dependent.

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Policy's conditions of eligibility. Employees who work on a temporary or substitute basis are not considered to be Employees for the purpose of the Policy. See also You, Your, Yours.

Employee's Eligibility Date means the later of:
a. the date of employment; or
b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:
a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative resources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is required by law to recognize which:
a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by the Policy.

Full-Time means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or

b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission; or

b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

Initial Dependent means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

Injury means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized heath care Facility.

Joint Commission means the Joint Commission on the Accreditation of Health Care Facilities.

Late Enrollee means an eligible Employee or Dependent who requests enrollment under the Policy more than [30] days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and Dependent Coverage sections of the Policy.

Medical Emergency means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;

b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;

c. in accordance with generally accepted medical practice;

d. not for the convenience of a Covered Person;

e. the most appropriate level of medical care the Covered Person needs; and

f. furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

Mental Health Center means a Facility which mainly provides treatment for people with mental health problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission;

b. approved for its stated purpose by Medicare; or

c. accredited or licensed by the state of New Jersey to provide mental health services.

Mental and Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods on psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

Non-Covered Charges are charges which do not meet the Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in the Policy and in this [certificate], or which are specifically identified as Non-Covered Charges or are otherwise not covered by the Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

[PLAN B]

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under the Policy or any other policy or plan:

a. as an Employee or Dependent; and

b. with or without interruption of coverage.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by Your Employer. [Note: If the "Plan" definition is employed, references in this [certificate] to "Policy" should be changed to read "Plan"].

Planholder means Your Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this [certificate] to "Policyholder" should be changed to read "Planholder"].

Policy means the group policy, including the application and any riders, amendments, or endorsements, between Your Employer and [Carrier].

Policyholder means Your Employer who purchased the Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treat-

ment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of the Policy.

[PLANS C, D, E]

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under the Policy or any other policy or plan:

a. as an Employee or Dependent; and

b. with or without interruption of coverage.

Plan means the [Carrier's] group health benefit plan purchased by Your Employer. [Note: If the "Plan" definition is employed, references in this [certificate] to "Policy" should be changed to read "Plan"].

Planholder means Your Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this [certificate] to "Policyholder" should be changed to read "Planholder"].

Policy means the group policy, including the application and any riders, amendments, or endorsements, between Your Employer and [Carrier].

Policyholder means Your Employer who purchased the Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of the Policy.

Reasonable and Customary means an amount that is not more than the [lesser of:

- the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
- the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under the Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

b. approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the **Schedule of Insurance** contained in the Policy and in this [certificate].

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Center (see Extended Care Center.)

Small Employer means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a. intensive care units;

b. cardiac care units;

c. neonatal care units; and

d. burn units.

Substance Abuse means abuse of or addiction to drugs.

Substance Abuse Centers are Facilities that mainly provide treatment for people with substance abuse problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or

b. approved for its stated purpose by Medicare.

Surgery means:

a. the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

b. the correction of fractures and dislocations;

c. Reasonable and Customary pre-operative and post-operative care; or

d. any of the procedures designated by Current Procedural Terminology codes as Surgery.

Therapeutic Manipulation means the treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydro therapy or other treatment of similar nature.

Total Disability or Totally Disabled means, except as otherwise specified in the Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience,

and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

[We, Us, Our and **[Carrier]** mean [Carrier].]

[You, Your and Yours mean an Employee who is insured under the Policy.]

EMPLOYEE COVERAGE

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of the Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not insure an Employee unless the Employee is an Actively at Work Full-Time Employee.

Enrollment Requirement

[Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:

a. more than [30] days after the Employee's Eligibility Date; or

b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to the Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under the Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under the Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee must enroll under the Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

The Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under the Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under the Policy from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under the Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

When Employee Coverage Starts

You must be Actively at Work, and working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. If You are not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of Your Coverage until You return to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.

You must elect to enroll and agree to make the required payments, if any, within [30] days of the Employee's Eligibility Date. If You do this within [30] days of the Employee's Eligibility Date, Your coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the scheduled Effective Date of Your coverage.

When Employee Coverage Ends

Your insurance under the Policy will end on the first of the following dates:

a. [the date] You cease to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, layoff, leave of absence, and the end of employment.

b. [the date] You stop being an eligible Employee under the Policy.

c. the date the Policy ends, or is discontinued for a class of Employees to which You belong.

d. the last day of the period for which required payments are made for You.

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This [certificate's] benefits provisions explain these situations. Read this [certificate's] provisions carefully.

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

Your eligible Dependents are Your:

a. legal spouse;

b. unmarried Dependent children who are under age 19; and

c. unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or

b. eligible for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this [certificate].

Your "unmarried Dependent child" includes:

a. Your legally adopted children,

b. Your stepchildren if such stepchildren depend on You for most of their support and maintenance, and

c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

You may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Policy, such a child may stay eligible for Dependent health benefits past the Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached the Policy's age limit;

b. the child became insured by the Policy or any other policy before the child reached the age limit and stayed continuously insured after reaching such limit; and

c. the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send [Carrier] written proof that the child is incapacitated and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when Your coverage does.

Enrollment Requirement

You must enroll Your eligible Dependents in order for them to be covered under the Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:

a. enroll a Dependent and agree to make the required payments more than [30] days after the Dependent's Eligibility Date;

b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who You have not elected to enroll; or

c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to the Policy's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

However, if You previously waived coverage for Your spouse or eligible Dependent children under the Policy and stated at that time that such waiver was because they were covered under another group plan and You now elect to enroll them in the Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;

b. divorce;

c. death of Your spouse; or

d. termination of the other plan's coverage.

But, You must enroll Your spouse or eligible Dependent children within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Policy, to be a Late Enrollee, if:

a. You are under legal obligation to provide coverage due to a court order; and

b. You enroll Your spouse or eligible Dependent children within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

When Dependent Coverage Starts

In order for Your dependent coverage to begin You must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below and to all of the terms of the Policy, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. The Dependent's Eligibility Date, or

b. the date You become insured for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a. the date You sign the enrollment form; or

b. the date You become insured for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify [Carrier] of a Newly Acquired Dependent within [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:

a. the date You notify [Carrier] and agree to make any additional payments, or

b. the Dependent's Eligibility Date for the Newly Acquired Dependent.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date Your Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

Newborn Children

[Carrier] will cover Your newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:

a. If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.

b. If You are not covered for Dependent child coverage on the date the child is born, You must:

- make written request to enroll the newborn child; and
- pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's insurance under the Policy will end on the first of the following dates:

a. [the date] Your coverage ends;

b. the date You stop being a member of a class of Employees eligible for such coverage;

c. the date the Policy ends;

d. the date Dependent coverage is terminated from the Policy for all Employees or for Your class;

e. the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons;

f. at 12:01 A.M. on the date the Dependent stops being an eligible Dependent.

Read this [certificate] carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer XYZ Health Care Network, and the [Carrier]

The Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by the Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

The Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of the Policy. You should read Your [certificate] carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If You have any questions after reading Your [certificate], You should call [Carrier] [Group Claim Office at the number shown on Your identification card.]

[**Note:** Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions

a. *Primary Care Practitioner* (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.

b. *Provider Organization* (PO) means a network of health care Providers located in a Covered Person's Service Area.

c. *Network Benefits* mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.

d. *Out-Network Benefits* mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.

e. *Service Area* means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for the Policy is the [XYZ] Provider Organization. The Policy requires that the Covered Person uses the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care Practitioner (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person **must** obtain an authorized referral from his or her PCP **before** he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-Network Benefits.

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, the Covered Person may only be eligible for Out-Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

Out-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by a [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out-Network Benefits.

Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. [Carrier] will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

Utilization Review

The Policy has utilization features. See the **Utilization Review Features** section of this [certificate].

Benefits

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of the Policy.

[**Note:** Used only if coverage is offered as POS.]

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in the Policy and in this [certificate].

BENEFIT PROVISION

The Cash Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by the Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by the Policy. And what [Carrier] pays is based on all the terms of the Policy.

Family Deductible Limit

The Policy has a family deductible limit of two cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of the Policy.

Co-Insurance Cap

The Policy limits Co-Insuance amounts each Calendar Year **except** as stated below. The Co-Insurance Cap cannot be met with:

a. Non-Covered Charges;
b. Cash Deductibles;
c. Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse; and
d. Co-Payments.

There are Co-Insurance Caps for:

a. each Covered Person; and
b. each Covered Family.

The Co-Insurance Caps are shown in the Schedule.

Each Covered Person's Co-Insurance amounts are used to meet his or her own Co-Insurance Cap. But, all amounts used to meet the cap must actually be paid by a Covered Person out of his or her own pocket.

Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.

Once two Covered Persons in a family meet their individual Co-Insurance amounts, [Carrier] will waive the family's Co-Insurance for the rest of that Calendar Year.

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the Co-Insurance Cap.

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans

The benefits [Carrier] will pay may be affected by a Covered Person being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan

The Employer who purchased the Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet the Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which the Policy starts;

b. The Policy would have paid benefits for the charges, if the Policy had been in effect;

c. The Covered Person was covered by the old plan when it ended and enrolled in the Policy on its Effective Date; and

d. The Policy starts right after the old plan ends.

Extended Health Benefits

If the Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under the Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of the Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends; or

b. one year from the date the person's insurance under the Policy ends; or

c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

[PLAN B]

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this [certificate's] **Emergency Room Co-Payment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this [certificate].

Hospital Co-Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $200 Co-Payment for each day of confinement, up to a maximum of $1,000 per Period of Confinement, subject to a maximum $2,000 Co-Payment per Calendar Year.

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

[PLANS C, D, E]

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this [certificate's] **Emergency Room Co-Payment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this [certificate].

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

Extended Care or Rehabilitation Charges

Subject to [Carrier's] Pre-Approval [Carrier] covers charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. start within 14 days of a Hospital stay; and

b. be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are a Non-Covered Charge.

But [Carrier] limits what [Carrier] will pay for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this [certificate].

Extended Care or Rehabilitation Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges:

Subject to [Carrier's] Pre-Approval, when home health care can take the place of Inpatient care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b. physical therapy;
c. occupational therapy;
d. medical social work;
e. nutrition services;
f. speech therapy;
g. home health aide services;
h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:

a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
b. The services and supplies must be:
- ordered by the Covered Person's Practitioner;
- included in the home health care plan; and
- furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.

d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

e. [Carrier] does not pay for:
- services furnished to family members, other than the patient; or
- services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But [Carrier] limits what [Carrier] will pay for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this [certificate].

Practitioner's Charges for Surgery

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

Second Opinion Charges

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b. are not business associates of the Practitioner who recommended the Surgery; and
c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges

[Carrier] covers charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges

Subject to [Carrier] Pre-Approval, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered Person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal illness or terminal injury.

"Terminally ill" or "terminally injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of the Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
a. needed for palliative and supportive care;
b. ordered by the Covered Person's Practitioner;
c. included in the Hospice care program; and
d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:
a. services and supplies provided by volunteers or others who do not regularly charge for their services;
b. funeral services and arrangements;
c. legal or financial counseling or services; or
d. treatment not included in the Hospice care plan.

Hospital Care Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Alcohol Abuse

[Carrier] pays benefits for the Covered Charges a Covered Person incurs for the treatment of Alcohol Abuse the same way [Carrier] would for any other Illness, if such treatment is prescribed by a Practitioner. But [Carrier] does not pay for Custodial Care, education, or training.

Treatment may be furnished by:
a. a Hospital;
b. a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c. a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Pregnancy

The Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges

[Carrier] covers Birthing Center charges made by a Practitioner for prenatal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a. nursery charges;
b. charges for routine Practitioner's examinations and tests; and
c. charges for routine procedures, like circumcision.

Subject to all of the terms of the Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

Anesthetics and Other Services and Supplies

[Carrier] covers anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. [Carrier] covers the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But [Carrier] does not pay for replacements or repairs.

Blood

[Carrier] covers blood, blood products, blood transfusions and the cost of testing and processing blood. But [Carrier] does not pay for blood which has been donated or replaced on behalf of the Covered Person.

Ambulance Charges

[Carrier] covers Medically Necessary and Appropriate charges for transporting a Covered Person to:

a. a local Hospital if needed care and treatment can be provided by a local Hospital;
b. the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c. transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But [Carrier] does not pay for chartered air flights. And [Carrier] will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment

Subject to [Carrier's] Pre-Approval, [Carrier] covers charges for the rental of Durable Medical Equpiment needed for therapeutic use. At [Carrier's] option, and with [Carrier's] Pre-Approval, [Carrier] may cover the purchase of such items when it is less costly and more practical than rental. But [Carrier] does not pay for:

a. any purchases without [Carrier's] advance written approval;
b. replacements or repairs; or
c. the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Treatment of Wilm's Tumor

[Carrier] pays benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. [Carrier] treats such charges the same way [Carrier] treats Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. [Carrier] pays benefits for this treatment even if it is deemed Experimental or Investigational. What [Carrier] pays is based on all of the terms of the Policy.

X-Rays and Laboratory Tests

[Carrier] covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this [certificate's] **Preventive Care** section, [Carrier] does not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information;
   3. The United States Pharmacopeia Drug Information; or
c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does not cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental and Nervous Conditions and Substance Abuse section of the Policy.

COVERED CHARGES WITH SPECIAL LIMITATIONS

Dental Care and Treatment

[Carrier] covers:

a. the diagnosis and treatment of oral tumors and cysts; and
b. the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:

a. the Injury occurs while the Covered Person is insured under any health benefit plan;
b. the Injury was not caused, directly or indirectly by biting or chewing; and
c. all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event does [Carrier] cover orthodontic treatment.

Treatment for Temporomandibular Joint Disorder (TMJ)

[Carrier] covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, [Carrier] does not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices

[Carrier] limits what [Carrier] pays for prosthetic devices. Subject to [Carrier] Pre-Approval, [Carrier] covers only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Covered Person's body, or be needed due to a functional birth defect in a covered Dependent child. [Carrier] does not pay for replacements, unless they are Medically Necessary and Appropriate. [Carrier] does not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthetic Devices which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Mammogram Charges

[Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of the Policy, and the following limitations:

[Carrier] will cover charges for:

a. one baseline mammogram for a female Covered Person, ages 35-39;
b. one mammogram, every 2 years, for a female Covered Person, ages 40-49, or more frequently, if recommended by a Practitioner; and
c. one mammogram, every year, for a female Covered Person ages 50 and older.

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late

Enrollees request enrollment during any [30] day enrollment period provided for in the Policy. See this [certificate's] **EMPLOYEE COVERAGE** and **DEPENDENT COVERAGE** sections to determine if a Covered Person is a Late Enrollee. The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.

Pre-Existing Conditions

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions until the Covered Person has been continuously covered by the Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a Covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in the Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under the Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under the Policy starts. If the Employer has included an eligibility waiting period in the Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] **only** covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below.

a. *Chelation Therapy*—means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

b. *Chemotherapy*—the treatment of malignant disease by chemical or biological antineoplastic agents.

c. *Dialysis Treatment*—the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

d. *Radiation Therapy*—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

e. *Respiration Therapy*—the introduction of dry or moist gases into the lungs.

[Carrier] covers the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy*—the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.

g. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

h. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

i. *Physical Therapy*—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss or limb.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

j. *Infusion Therapy*—subject to [Carrier] Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. **Charges in connection with Infusion Therapy which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to:

a. $500 per Covered Person for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and

b. $300 per Covered Person for all other Covered Persons.

These charges are not subject to the Cash Deductible or Co-Insurance.

Therapeutic Manipulation

[Carrier] limits what [Carrier] covers for therapeutic manipulation to 30 visits per Calendar Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.

Mental and Nervous Conditions and Substance Abuse

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. [Carrier] includes a condition under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

A Covered Person may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. Covered Charges for the treatment of Mental and Nervous Conditions and Substance Abuse include charges incurred for Prescription Drugs.

The Covered Person must pay the Co-Insurance shown on the Schedule for Covered Charges for such treatment. [Carrier] limits what [Carrier] pays each Calendar Year to $5,000.00 for combined Inpatient and Outpatient treatment. [Carrier] limits what [Carrier] pays Per Lifetime to $25,000.00 combined Inpatient and Outpatient benefit.

[Carrier] does not pay for Custodial Care, education, or training.

Transplant Benefits

[Carrier] covers Medically Necessary and Appropriate services and supplies for the following types of transplants:

a. Cornea
b. Kidney
c. Lung
d. Liver
e. Heart
f. Pancreas
g. Allogenic Bone Marrow
h. Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:

- Leukemia
- Lymphoma

- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
  —SCID
  —WISCOT Aldrich
- Subject to [Carrier] Pre-Approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **Charges in connection with such treatment of breast cancer which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

IMPORTANT NOTICE

[The Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or

b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under the Policy. See the **Utilization Review Features** section for details.]

[The Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[The Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.]

[What [Carrier] pays is subject to all of the terms of the Policy. Read this [certificate] carefully and keep it available when consulting a Practitioner.

If You have any questions after reading this [certificate], You should [call The Group Claim Office at the number shown on Your identification card.]

The Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with the Policy's utilization review features, he or she will not be eligible for full benefits under the Policy.

Compliance with the Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;

b. the Covered Person being eligible for coverage under the Policy at the time the Covered Charges are incurred; and

c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of the Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Policy is not payable under the Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives, like home health care or other outpatient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;

b. the named attending Practitioner; and

c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;

b. he or she changes attending Practitioners; or

c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;

b. the Covered Person's group plan number;

c. the reason for the admission;

d. the name and location of the Hospital;

e. when the admission occurred; and

f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and

b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%], if:

a. the Covered Person does not request a pre-hospital review; or

b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or

c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or

d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges by 50%], if:

a. [ABC] is not notified of the admission at the times and in the manner described above;

b. the Covered Person does not request a continued stay review; or

c. the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends by 50% as a penalty for non-compliance.

Penalties cannot be used to meet the Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or

b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under the Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;

b. is not a business associate of the Covered Person's Practitioner; and

c. does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of the Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the Proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery by 50%], if:

a. the Covered Person does not request a pre-surgical review; or

b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or

c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done; or

d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay

b. spinal cord Injury

c. severe burn over 20% or more of the body

d. multiple injuries due to an accident

e. premature birth

f. CVA or stroke

g. congenital defect which severely impairs a bodily function

h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure

i. terminal illness, with a prognosis of death within 6 months

j. Acquired Immune Deficiency Syndrome (AIDS)

k. chemical dependency

l. mental, nervous and psychoneurotic disorders

m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes:
a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
- [DEF]
- attending Practitioner
- Covered Person
- Covered Person's family, if any; and

d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:
a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the Utilization Review Features will not apply.]]

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of *acupuncture* except when used as a substitute for other forms of anesthesia.

Services for *ambulance* for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a *Christian Science* Practitioner.

Completion of claim forms.

Services or supplies related to *cosmetic surgery,* except as otherwise stated in the Policy, unless it is required as a result of an Illness or Injury sustained while covered under the Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to *custodial* or *domiciliary* care.

Dental care or treatment, including appliances, except as otherwise stated in the Policy.

Services or supplies, the primary purpose of which is *educational* providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a. exams to determine the need for (or changes of) *eyeglasses* or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's *family:* spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance *fertility* using artificial and surgical drugs and procedures, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to *Hearing aids and hearing exams* to determine the need for hearing aids or the need to adjust them.

Services or supplies related to *Herbal medicine.*

Care or treatment by means of *high dose chemotherapy,* except as otherwise stated in the Policy.

Services or supplies related to *Hypnotism.*

Services or supplies because the Covered Person engaged, or tried to engage, in an *illegal occupation* or committed or tried to commit a felony.

Illness or *Injury,* including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to *Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.*

Supplies related to *Methadone* maintenance.

Any charge identified as a *Non-Covered Charge* or which are specifically limited or excluded elsewhere in the Policy and this [certificate], or which are not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except insulin needles and syringes.

Services provided by a licensed *pastoral counselor* in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Services or supplies that are not furnished by an eligible *Provider.*

Services related to *Private-Duty Nursing care,* except as provided under the Home Health Care section of this [certificate].

The amount of any charge which is greater than a *Reasonable and Customary Charge.*

Services or supplies related to *rest or convalescent cures.*

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, *Routine examinations* or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to *Routine Foot Care.*

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a *social worker,* except as otherwise stated in the Policy.

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;

b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

c. for which a Covered Person would not have been charged if he or she did not have health care coverage;

d. provided by or in a government Hospital unless the services are for treatment:

- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Stand-by services required by a Provider.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Policy.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a *war,* declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this [certificate's] **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this [certificate] at the same time.

Continuation Under CCR and NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this [certificate's] CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this [certificate]:

If a Covered Person elects to continue his or her group health benefits under both this [certificate's] CCR and any other continuation sections, the continuations:

a. start at the same time;

b. run concurrently; and

c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and

b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following **COBRA CONTINUATION RIGHTS** section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

a. Your Employer is subject to the **COBRA CONTINUATION RIGHTS** section in which case;

b. the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Policy as:

a. an active, covered Employee;

b. the spouse of an active, covered Employee; or

c. the Dependent child of an active, covered Employee. Any person who becomes covered under the Policy during a continuation provided by this section is not a qualified continuee.

If An Employee's Group Health Benefits Ends

If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:

a. You were not terminated due to gross misconduct; and

b. You are not entitled to Medicare.

The continuation:

a. may cover You and any other qualified continuee; and

b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours, You may elect to extend Your 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and

b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If You die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Policy, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or

b. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or

b. the loss of dependent eligibility, as defined in the Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue the Policy's group health benefits;

b. the monthly premium he or she must pay to continue such benefits; and

c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or

b. the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of [Carrier], if:

a. The Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or

b. The Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d. with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

e. the date the Policy ends;

f. the end of the period for which the last premium payment is made;

g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;

h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this [certificate's] **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If an Employee's Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What the Employee Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed insured under the Policy on a regular basis. It includes any amount that Your Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under the Policy on a regular basis. Any modifications made under the Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for You to continue.

When Continuation Ends

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;

b. the date the Covered Person becomes eligible for Medicare;

c. the end of the period for which the last premium payment is made;

d. the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-existing Condition of the Covered Person;

e. with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;

f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or

g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been insured by the Policy for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, You must give Your Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, insured under the Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay [Carrier] on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if You stop paying.

b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;

c. the date the Policy ends or is amended to end for the class of Employees to which You belonged; or

d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

- Your Employer must allow for a leave of absence under Federal law in which case;
- the section applies to You.

If An Employee's Group Health Coverage Ends

Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your group health benefits insurance will be continued. Dependents' insurance may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date You return to Full-Time work;

b. the end of a total leave period of 12 weeks in any 12 month period;

c. the date on which Your coverage would have ended had You not been on leave; or

d. the end of the period for which the premium has been paid.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were insured under the Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of Your death; or

b. the date the Dependent is no longer eligible under the terms of the Policy.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health benefits for Your former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under the Policy on the date the group health benefits ends. See **exceptions** below.

Exceptions

No former spouse may use this conversion right:

a. if he or she is eligible for Medicare; or

b. if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under the Policy ends.

After group health benefits under the Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under the Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under the Policy.

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by the Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends

Insurance for You and Your Dependents will end on the date You become an HMO member.

Benefits After Group Health Benefits Insurance Ends

When You become an HMO member, the **Extended Health Benefits** section of this [certificate] will not apply to You and Your Dependents.

Exception:

IF, on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing Conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for total disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre-Existing Conditions limit expires, or
- hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THE POLICY

Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If You elect to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period

[Carrier] and the Policyholder will agree when this period will be. If You request insurance during this period, You and Your Dependents will be insured on the date such period ends.

request made because:
- an HMO ends its operations
- Employee moves outside the HMO service area

If You request insurance because membership ends for these reasons, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:
- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made because an HMO becomes insolvent

If You request insurance because membership ends for this reason, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made at any other time

You may request insurance at any time other than that described above. In this case, You and Your Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by the Policy for such insurance, will not apply on the transfer date:
- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre-Existing Conditions provisions.

Charges not covered

Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit

The total amount of benefits to be paid for each person will be the maximum benefit specified in the Policy, regardless of any interruption in such person's insurance under the Policy.

Right to change premium rates

[Carrier] has the right to change premium rates when, in its opinion, its liability under the Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;

b. group hospital or surgical plans, or other service or prepayment plans on a group basis;

c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;

d. programs or coverages required by law;

e. group or group-type hospital indemnity benefits which exceed $250.00 per day;

f. group or group-type hospital indemnity benefits of $250.00 per day or less for which You pay part of the premium; or

g. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. group or group-type hospital indemnity benefits of $250.00 per day or less for which You pay the entire premium; nor

d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carrier's] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pays less than [Carrier] would otherwise pay, [Carrier] applies only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information

In order to coordinate benefits, [Carrier] needs certain information. You must supply [Carrier] with as much of that information as You can. But if You cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan has been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under the Policy when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. the Policy;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

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

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

Determination of primary or secondary coverage

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

The Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case the Policy will be primary.

If there is a dispute as to which policy is primary, the Policy will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.

If the Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of the Policy will apply if:

- the covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.

If the Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or

b. the benefits that would have been paid if the Policy had been primary.

Medicare

If the Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to Your Employer's Policy. You must contact Your Employer to find out if Your Employer is subject to Medicare as Secondary Payor rules.

If Your Employer is subject to such rules, this **Medicare as Secondary Payor** section applies to You.

If Your Employer is NOT subject to such rules, this **Medicare as Secondary Payor** section does not apply to You, in which case, Medicare will be the primary health plan and the Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how the Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the United States Social Security Act, as amended from time to time.

b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.

c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".

[d. "We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to You or Your insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse
b. an Employee or insured spouse who is under age 65, or
c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A)—The Medicare eligible may choose the Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Policy is Primary** section below, for details.

Option (B)—The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When the Policy is primary

When a Medicare eligible chooses the Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Policy. Coverage under the Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a Covered Person who is:

a. under age 65; and

b. eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or

b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When a Covered Person Becomes Eligible For Medicare

When a Covered Person becomes eligible for Medicare by reason of disability, Medicare is the primary plan. The Policy is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and

b. with respect to an ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by the Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under the Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;

b. a satisfied judgment; or

c. other means.

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or

b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under the Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.

b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an

Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.

b. If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.

c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:

- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

EXHIBIT X
PART 1

EXPLANATION OF BRACKETS—CERTIFICATE FORMS

(PLANS A, B, C, D, E)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

1. Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC].

2. Some areas of variability are noted with brief explanations within the text. Examples include: use of Planholder, PPO, and POS text.

3. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.

4. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in the certificate forms.

1. The face page text may be modified to be consistent with a Carrier's methods of certificate personalization. The certificate level data that is illustrated on the face page may appear on a separate schedule or sticker, or may be incorporated in the body of the certificate. Carriers may also elect to issue no-name certificates.

2. The term "certificate" may be replaced with certificate booklet, certificate of insurance, employee booklet, booklet certificate, evidence of coverage, or similar titles used to identify the document provided to employees insured under an employer's group policy.

3. Variable amounts appearing in the Schedule of Insurance may be included on the Schedule, or specified on the face page, sticker, or separate schedule, as discussed above.

4. The Payment of Premiums—Grace Period section of the General Provisions may be omitted from the certificate, at the option of the Carrier.

5. Dividend text which appears both on the Face Page and in the General Provisions should only be included by Carriers that could pay dividends. At the option of the carrier, such text may be omitted from the certificate.

6. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.

7. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.

8. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.

9. The Definition of "You, Your and Yours" may be omitted. If omitted, references throughout the text to You, Your and Yours should be replaced with Employee terminology.

10. The Waiting Period provision of the Employee Coverage provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.

11. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.

12. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, either the text must conform to the text of the standard form, except that the penalty for non-compliance may be adjusted to reflect a different percentage, or to utilize a dollar penalty; or the text must be submitted to the Board and the Department of Insurance for review and approval prior to use, as specified in regulation.

13. The Alternate Treatment Features provisions may be omitted. Carrier may administratively provide for such provisions. If included in the policy, the text must conform to the text of the standard form.

14. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.

(RIDERS)

All text which is enclosed in brackets [ ] is variable.

Some areas of variability are self-explanatory. Examples include: [Carrier], [XYZ], and [ABC].

Some areas of variability are noted with brief explanations on the text. An example is the rider closure.

The Co-Payment amounts in the Mental and Nervous Conditions and Substance Abuse rider may vary to be consistent with any other Co-Payment amounts allowed for HMO plans.

The Appeals Procedure in the Mental and Nervous Conditions and Substance Abuse rider may vary to conform to a carrier's and/or health care review organization's procedure.

EXHIBIT X
PART 2

EXPLANATION OF BRACKETS (HMO PLAN)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

a. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contract Holder], and [ABC].

b. Some areas of variability are noted with brief explanations within the text.

c. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.

d. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Evidence of Coverage forms.

1. The face page text may be modified to be consistent with a Carrier's methods of Evidence of Coverage personalization. The data reflected on the face page may appear on a separate schedule or sticker, or may be incorporated in the body of the document. Carriers may also elect to use a no-name Evidence of Coverage.

2. The term "Evidence of Coverage" may be replaced with another similar term to adapt to a carrier's typical practice of providing employees with proof of coverage documents.

3. Co-Payments may be elected by the Employer, subject to the availability specified in regulation.

4. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements.

5. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.

6. OB/GYNs can be considered Primary Care Physicians.

7. Eligible class references can be removed.

8. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.

9. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.

10. Small Claims Waiver can be deleted.

11. Transfer of Primary Care Physician can occur according to Carrier administration.

EXHIBIT Y

[Carrier] **HMO PLAN**

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION EVIDENCE OF COVERAGE

[[Carrier] certifies that the Employee named below is entitled to Covered Services and Supplies described in this Evidence of Coverage, as of the effective date shown below, subject to the eligibility and effective date requirements of the Contract.]

[The Contract is an agreement between [Carrier] and the Contract Holder. This Evidence of Coverage is a summary of the Contract Provisions that affect Your Coverage. All Covered Services and Supplies and Non-Covered Services and Supplies are subject to the terms of the Contract.]

CONTRACT HOLDER: [ABC Company]
GROUP CONTRACT NUMBER: [G-12345]
[EMPLOYEE: [John Doe]]
[CERTIFICATE NUMBER: [C-123456]]
EFFECTIVE DATE OF EVIDENCE OF COVERAGE: [January 1, 1994]
[COVERED CLASSES:
[All Employees of the Contract Holder (and its Associated Companies) who permanently reside in the Service Area and are eligible or covered under the Group Care Health Plan.]]
SERVICE AREA: [The State of New Jersey]
AFFILIATED COMPANIES: [DEF Company]
COST OF THE COVERAGE:
[The coverage in this Evidence of Coverage is Contributory Coverage. You will be informed of the amount of Your contribution when You enroll.]
[HMO's Address: [400 Main Street
Chester, New Jersey 00000]

This Evidence of Coverage replaces any older Evidence of Coverage isued to You for the Group Health Care Plan.

[Secretary President]

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I. SCHEDULE OF SERVICES

THE SERVICES OR SUPPLIES COVERED ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER MEMBER, UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	COPAYMENTS[/COINSURANCE]:
HOSPITAL SERVICES:	
INPATIENT	$150 Copayment/day for a maximumum of 5 days/admission. Maximum Copayment $1,500/Calendar Year. Unlimited days.
OUTPATIENT	$15 Copayment/visit
DOCTOR SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT	None
OUTPATIENT	$15 Copayment/visit; no Copayment if any other Copayment applies.
EMERGENGY ROOM	$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours as a result of the same or related Illness or Injury for which the person visited the Emergency Room)
OUTPATIENT SURGERY	$15 Copayment/visit.
HOME HEALTH CARE	Unlimited days, if preapproved.
HOSPICE SERVICES	Unlimited days, if preapproved.
MATERNITY (PRE-NATAL CARE)	$25 Copayment for initial visit only.
MENTAL NERVOUS CONDITIONS AND SUBSTANCE ABUSE:	
OUTPATIENT	$15 Copayment/visit maximum 20 visits/Calendar Year.

INPATIENT	$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment $1,500/Calendar Year. Maximum of 30 days inpatient care/ Calendar Year. One Inpatient day may be exchanged for two Outpatient visits.
PODIATRIC	$15 Copayment/visit (excludes Routine Foot Care).
PRE-ADMISSION TESTING	$15 Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with $15 Copayment.]
PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES	$15 Copayment/visit.
PRIMARY CARE SERVICES	$15 Copayment/visit.
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceeded by a Hospital Inpatient Stay.
SECOND SURGICAL OPINION	$15 Copayment/visit.
SPECIALIST SERVICES	$15 Copayment/visit.
SKILLED NURSING CENTER	Unlimited days, if preapproved.
THERAPY SERVICES	$15 Copayment/visit.
DIAGNOSTIC SERVICES (OUTPATIENT)	$15 Copayment/visit.

NOTE: NO SERVICES OR SUPPLIES WILL BE PROVIDED IF A MEMBER FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN. READ THE ENTIRE EVIDENCE OF COVERAGE CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS EVIDENCE OF COVERAGE CALLED "NON-COVERED SERVICES AND SUPPLIES" TO SEE WHAT THE SERVICES AND SUPPLIES ARE FOR WHICH A MEMBER IS NOT ELIGIBLE.

II. DEFINITIONS

The words shown below have specific meanings when used in this Evidence of Coverage. Please read these definitions carefully. Throughout the Evidence of Coverage, these defined terms appear with their initial letters capitalized. They will help Members understand what services are provided under the Group Health Care Plan.

[**ACTIVELY AT WORK or ACTIVE WORK.** Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.]

ALCOHOL ABUSE. Abuse of or addiction to alcohol.

AMBULANCE. A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by applicable state and local law.

AFFILIATED COMPANY. A corporation or other business entity affiliated with the Contract Holder through common ownership of stock or assets.

BOARD. The Board of Directors of the New Jersey Small Employer Health Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

COINSURANCE. The percentage of Covered Services or Supplies that must be paid by a Member. Coinsurance does not include Copayments.]

CONTRACT. The contract, including the application and any riders, amendments or endorsements, between the Employer and [Carrier] which defines the terms and conditions under which the [Carrier] agrees [to provide or arrange] health care for the Employer's Employees [or members].

CONTRACT HOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which Member must pay for certain Covered Services or Supplies.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this Evidence of Coverage.

Read the entire Evidence of Coverage to find out what We limit or exclude.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help a Member meet his or her routine daily needs; or

(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

Your:

a. legal spouse;

b. unmarried Dependent child who is under age 19; and

c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Under certain circumstances, an incapacitated child is also a Dependent. See the Eligibility section.

Your "unmarried Dependent child" includes Your legally adopted child, Your step-child if such step-child depends on You for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who is covered by the Group Health Care Plan as an Employee.

At Our discretion, We can require proof that a person meets the definition of a Dependent.

DEPENDENT'S ELIGIBILITY DATE.

The later of:

a. Your Employee Eligibility Date; or

b. the date the person first becomes a Dependent.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

(a) radiology, ultrasound, and nuclear medicine;

(b) laboratory and pathology; and

(c) EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION. Our sole right to make a decision or determination.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;

(b) used primarily and customarily for a medical purpose;

(c) is generally not useful to a Member in the absence of an Illness or Injury; and

(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under the Group Health Care Plan for a Member.

EMPLOYEE. A Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Group Health Care Plan's conditions of eligibility.

EMPLOYEE ELIGIBILITY DATE.

a. the date of employment; or

b. the day after any applicable waiting period ends.

EMPLOYER. [ABC Company].

EXPERIMENTAL OR INVESTIGATIONAL.

Services or supplies which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or

(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or

(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition, as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

I. The American Medical Association Drug Evaluations;

II. The American Hospital Formulary Service Drug Information; or

III. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

[HEALTH CARE CENTER OR HEALTH CENTER. A place operated by or on behalf of an HMO where [Network] [Participating] Providers provide Covered Services and Supplies to Members.]

GROUP HEALTH CARE PLAN. The plan of health care coverage described in this Evidence of Coverage which a Contract Holder is providing for its Employees [or members].

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be approved for its stated purpose by Medicare; or

(b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited as a hospital by the Joint Commission; or

(b) be approved as a hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A facility for the aged or substance abusers is not a Hospital.

ILLNESS. A sickness or disease suffered by a Member. A Mental and Nervous Condition is not an Illness.

INITIAL DEPENDENT. Those eligible Dependents You have at the time You first become eligible for Employee coverage. If at the time You do not have any eligible Dependents, but later acquire them, the first eligible Dependents You acquire are Your Initial Dependents.

INJURY. Damage to a Member's body due to accident, and all complications arising from that damage.

INPATIENT. Member if physically confined as a registered bed patient in a Hospital or other recognized heath care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

LATE ENROLLEE. An eligible Employee or Dependent who requests enrollment under the Group Health Care Plan more than [30] days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and **Dependent Coverage** sections appearing on later pages.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Examples of Medical Emergencies include, but are not limited to, heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;

(b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;

(c) in accordance with generally accepted medical practice;

(d) not for a Member's convenience;

(e) the most appropriate level of medical care that a Member needs; and

(f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, the fact that a Non-participating Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER. An eligible person who is covered under this Contract (includes Subscriber/covered Employee and covered Dependents, if any).

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission;

(b) approved for its stated purpose by Medicare; or

(c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies.

NEWLY ACQUIRED DEPENDENT. An eligible Dependent You acquire after You already have coverage in force for Initial Dependents.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-covered Services and Supplies, or which exceed any of the limitations shown in this Evidence of Coverage.

NON- [NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not a [Network] [Participating] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and

(b) provides medical services which are within the scope of the nurse's license or certificate and are covered by the Group Health Care Plan.

OUTPATIENT. Member if registered at a Practitioner's office or recognized health care facility and not an Inpatient; or services and supplies provided in such a setting.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PRACTITIONER. A medical practitioner who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and

(b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by the Group Health Care Plan.

[PRE-EXISTING CONDITION. An Illness or Injury or Mental or Nervous Condition which manifests itself in the six months before a Member's coverage under the Group Health Care Plan starts, and for which:

(a) a Member sees a doctor, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before the Member's coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date a Member's coverage starts is also a Pre-Existing Condition.

See the Non-Covered Services and Supplies section for details on how the Group Health Care Plan limits the services for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre- and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We determined based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary under the Group Health Care Plan. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REFERRAL. Specific direction or instruction from A Member's Primary Care Physician in conformance with Our policies and procedures that directs a Member to a facility or Provider for health care.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) be approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited for its stated purpose by the Joint Commission; or

(b) be approved for its stated purpose by Medicare.

SPECIALIST DOCTOR. A doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics] [or obstetrics/gynecology (for routine pre- and post-natal care, birth and treatment of the diseases and hygiene of females)].

SUBSCRIBER. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited for its stated purpose by the Joint Commission; or

(b) be approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;

(b) the correction of fractures and dislocations; or

(c) pre-operative and post-operative care.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment for the correction of a speech impairment, resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in this Evidence of Coverage, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

[WE, US, OUR. [Carrier].

YOU, YOUR AND YOURS. The Employee.]

III. ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the Group Health Care Plan, all of the Contract Holder's Employees [who are in an eligible class] will be eligible if the Employees are Actively at Work Full-Time Employees.

We will treat partners, proprietors and independent contractors like Employees if they meet the Group Health Care Plan's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not cover You unless You are an Actively at Work Full-Time Employee.

Enrollment Requirement

We will not cover You until You enroll and agree to make the required payments, if any. If You do this within [30] days of Your Employee Eligibility Date, coverage will start on the Your Employee Eligibility Date.

If You enroll and agree to make the required payments, if any:

a. more than [30] days after the Your Employee Eligibility Date; or

b. after You previously had coverage which ended because You failed to make a required payment,

We will consider You to be a Late Enrollee. Late Enrollees are subject to this Group Health Plan's Pre-Existing Conditions limitation.

However, if You initially waived coverage under the Group Health Care Plan, and You stated at that time that such waiver was because You were covered under another group plan, and You now elect to enroll under this Group Health Care Plan, We will not consider You to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;

b. divorce;

c. death of Your spouse; or

d. termination of the other plan's coverage.

But, You must enroll under this Group Health Care Plan within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date You become eligible.

[The Waiting Period

The Group Health Care Plan has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Group Health Care Plan from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under the Group Health Care Plan from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Group Health Care Plan from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

Multiple Employment

If You work for both the Contract Holder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat You as if only one firm employs You. And You will not have multiple coverage under the Group Health Care Plan.

When Employee Coverage Starts

You must be Actively at Work, and working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. If You are not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of Your coverage until You return to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.

You must elect to enroll and agree to make the required payments if any, within [30] days of the Employee Eligibility Date. If You do this within [30] days of the Employee Eligibility Date, Your coverage is scheduled to start on Your Employee Eligibility Date. Your Employee Eligibility Date is the scheduled Effective Date of Your coverage.

When Employee Coverage Ends

Your coverage under the Group Health Care Plan will end on the first of the following dates:

a. You cease to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.

b. You stop being an eligible Employee under the Group Health Care Plan.

c. the date this Group Health Care Plan ends, [or is discontinued for a class of Employees to which You belong.]

d. for which required payments are not made for You.

e. You move Your permanent residence outside the Service Area.

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This Evidence of Coverage's continuation provisions explain these situations. Read these provisions carefully.

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

Your eligible Dependents are:

a. Your legal spouse;

b. Your unmarried Dependent children who are under age 19; and

c. Your unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be defined by the accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Adopted Children and Step-Children

Your "unmarried Dependent children" include Your legally adopted children, if they depend on You for most of their support and maintenance, Your step-children and children under a court appointed guardianship. [Carrier] will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. [Carrier] will treat such a child this way whether or not a final adoption order is ever issued.

Eligible Dependents will not include any Dependent who is:

a. covered by the Group Health Care Plan as an Employee or

b. on active duty in the armed forces of any country.

Incapacitated Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Group Health Care Plan, such a child may stay eligible for Dependent health benefits past this Group Health Care Plan's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached this Group Health Care Plan's age limit; and

b. the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send Us written proof that the child is handicapped and depends on You for most support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for this more than once a year.

The child's coverage ends when Yours does.

Enrollment Requirement

You must enroll Your eligible Dependents in order for them to be covered under the Group Health Care Plan. [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:

a. enroll a Dependent more than [30] days after the Dependent's Eligibility Date;

b. in the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible Dependents who You have not elected to enroll; or

c. in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Group Health Care Plan's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

However, if You previously waived coverage for Your spouse or eligible Dependent children under the Group Health Care Plan and stated at that time that such waiver was because they were covered under another group plan, and You now elect to enroll them in this Group Health Care Plan, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;

b. divorce;

c. death of Your spouse; or

d. termination of the other plan's coverage.

But, Your spouse or eligible Dependent children must be enrolled by You within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Group Health Care Plan, to be a Late Enrollee, if:

a. You are under legal obligation to provide coverage due to a court order; and

b. Your spouse or eligible Dependent children are enrolled by You within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

When Dependent Coverage Starts

In order for Your dependent coverage to begin You must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below and to all of the terms of the Group Health Care Plan, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. the Dependent's Eligibility Date, or

b. the date You become covered for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee, the coverage is scheduled to start on the later of:

a. the date You sign the enrollment form; or

b. the date You become covered for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify Us of a Newly Acquired Dependent within the [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent will be covered from the later of:

a. the date You notify [Carrier], or

b. the Dependent's Eligbility Date for the Newly Acquired Dependent.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care facility; or is home confined on the date Your Dependent health coverage would otherwise start, [Carrier] will postpone the Effective Date of such coverage until the later of: the day after the Dependent's discharge from such facility; until home confinement ends.

Newborn Children

We will cover Your newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:

a. If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid.]

b. If You are not covered for Dependent child coverage on the date the child is born, You must:

- make written request to enroll the newborn child.

If the request is not made within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's coverage under the Group Health Care Plan will end on the first of the following dates:

a. Your coverage ends;

b. the date the Group Health Care Plan ends;

c. the date Dependent coverage is dropped from the Group Health Care Plan for all Employees eligible for such coverage;

d. At 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read this Evidence of Coverage carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group

benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted {policies} *contracts*.

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the Member that the person is no longer covered under the Group Health Care Plan:

(1) **Untenable Relationship:** After reasonable efforts, We and/or [Participating] Providers are unable to establish and maintain a satisfactory relationship with the Member or the Member fails to abide by our rules and regulations, or the Member acts in a manner which is verbally or physically abusive.

(2) **Misuse of Identification Card:** The Member permits any other person who is not authorized by Us to use any identification card We issue to the Member.

(3) **Furnishing Incorrect or Incomplete Information:** The Member furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under the Group Health Care Plan. This condition is subject to the provisions of the section Incontestability of Coverage.

(4) **Nonpayment:** The Member fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under the Group Health Care Plan.

(5) **Misconduct:** The Member abuses the system, including, but not limited to: theft, damage to [Our] [Participating Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.

(6) **Failure to Cooperate:** The Member fails to assist Us in coordinating benefits as described in the Coordination of Benefits and Services Section.

If We give the Member such written notice:

(a) that person will cease to be a Member for the coverage under the Group Health Care Plan immediately if termination is occuring due to **Misuse of Identification Card** (2 above) or **Misconduct** (5 above), otherwise, on the date 31 days after such written notice is given by Us; and

(b) no benefits will be provided to the Member under the coverage after that date.

Any action by Us under these provisions is subject to review in accordance with the Grievance Procedures We establish.

IV. COVERED SERVICES AND SUPPLIES

Members are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by Members of applicable copayments [or co-insurance] as stated in the applicable Schedule of Services.

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a Member, or elsewhere upon prior written Referral by a Member's Primary Care Physician:

1. **Office visits** during office hours, and during non-office hours when Medically Necessary.
2. **Home visits** by a Member's Primary Care Physician.
3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and
   e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a Member's employment).
4. **Diagnostic Services.**
5. **Casts and dressings.**
6. **Ambulance Service** when certified in writing as Medically Necessary by a Member's Primary Care Physician and approved in advance by Us.
7. **Infertility Services** except where specifically excluded in this Evidence of Coverage.
8. **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Member's body, or be needed due to the functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.
9. **Durable Medical Equipment** when ordered by a Member's Primary Care Physician and arranged through Us.
10. **Prescription Drugs and insulin syringes and insulin needles** when obtained through a Participating Provider.

(b) **SPECIALIST DOCTOR BENEFITS.** The following Services are covered when rendered by a Participating Specialist Doctor at the doctor's office[, or Health Center,] or any other Participating Facility or a Participating Hospital outpatient department during office or business hours upon prior written referral by a Member's Primary Care Physician. Services include, but are not limited to, the following:

1. Allergy (except serum injections which are covered when administered by a Member's Primary Care Physician)
2. Anesthesia
3. Cardiology
4. Endocrinology
[5. Gynecology and Obstetrics]
6. Internal Medicine
7. Neurology
8. Oncology
9. Ophthalmology
10. Oral Surgery (bone fractures, removal of tumors and orthodontogenic cysts or other approved surgical procedures by Us)
11. Orthopedics
12. Otolaryngology
13. Pathology
14. Pediatrics
15. Podiatry
16. Pulmonology
17. Radiology (except dental x-rays, unless related to Covered Services)
18. Surgery
19. Urology

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Provider upon prior written referral from a Member's Primary Care Physician, only at Participating Hospitals and Participating Providers (or at Non-participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval:

1. Semi-private room and board accommodations
2. Private accommodations [will be provided only when approved in advance by Us]. If a Member occupies a private room without such certification Member shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Participating Hospice, Participating Hospital, Participating Rehabilitation Center or Participating Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services
20. Private duty nursing only when approved in advance by Us
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas
22. Allogenic bone marrow transplants
23. Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma,

Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the Member is participating in a National Cancer Institute sponsored clinical trial.

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center [or Health Center] upon prior written referral by a Member's Primary Care Physician.

1. **Outpatient.** Members are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a Member's Primary Care Physician for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. Members are additionally eligible, upon referral by a Member's Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** Members are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

Chemical Dependency Admissions Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole discretion it is determined that Members have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services.

3. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

(e) **EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by a Member's Primary Care Physician in the event of a Medical Emergency as determined by Us.

1. A Member's Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a Member's health, Member shall call a Member's Primary Care Physician [or Health Center] [or Us] prior to seeking emergency treatment.

2. We will cover the cost of emergency medical and hospital services performed within or outside our service area without a prior written referral only if:

a. Our review determines that a Member's symptoms were severe and delay of treatment would have been detrimental to a Member's health, the symptoms occurred suddenly, and Member sought immediate medical attention. Conditions which require immediate treatment include, but are not limited to the following:
   1. heart attacks
   2. strokes
   3. convulsions
   4. serious burns
   5. obvious bone fractures
   6. wounds requiring sutures
   7. poisoning
   8. loss of consciousness

   A near-term delivery is not a Medical Emergency.

b. The service rendered is provided as a Covered Service or Supply under the Group Health Care Plan and is not a service or supply which is normally treated on a non-emergency basis; and

c. We and a Member's Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. Member shall be responsible for payment for services received unless We determine that a Member's failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.

3. In the event Members are hospitalized in a Non-participating facility, coverage will only be provided until Members are medically able to travel or to be transported to a Participating facility. If Members elect to continue treatment with Non-participating Providers, We shall have no responsibility for payment beyond the date Members are determined to be medically able to be transported.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by Members of all Copayments which would have been required had similar benefits been provided upon prior written referral to a Participating Provider.

4. Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after Members have been admitted to a facility as the result of a Medical Emergency shall require prior written referral or Members shall be responsible for payment.

5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if Members are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a Participating Provider upon prior written referral by a Member's Primary Care Physician.

1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a Participating Provider by a Member's Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a Member's Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a Member's condition within this time period and treatment is approved in writing by Us.

2. Chelation Therapy, Chemotherapy Treatment, Dialysis Treatment, Infusion Therapy and Radiation Therapy.

(g) **HOME HEALTH SERVICES.** The following Services are covered when rendered by a Participating Provider including, but not limited to, a Participating Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a Member's Primary Care Physician.

1. Skilled nursing services, provided by or under the supervision of a registered professional nurse.

2. Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to Member is skilled in nature.

3. Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a Member's medical condition.

4. Therapy Services as set forth above.

5. Hospice Care if Members are terminally ill with life expectancy of six months or less, as certified by the Member's Primary Care Physician, Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate care.

V. NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE *NOT* COVERED SERVICES UNDER THE GROUP HEALTH CARE PLAN.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless Member is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a Member.

Care and/or treatment by a **Christian Science Practitioner.**

Completion of claim forms.

Services or supplies related to **cosmetic surgery,** except as otherwise stated in this Evidence of Coverage, unless it is required as a result of an Illness or Injury sustained while covered under the Group Health Care Plan or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in this Evidence of Coverage.

Services or supplies, the primary purpose of which is **educational** providing the Member with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;

b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or

c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of Your **family:** spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance **fertility** using artificial and surgical procedures and drugs, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to **Hearing aids** and hearing examinations to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **Herbal medicine.**

Care or treatment by means of **high dose chemotherapy,** except as otherwise stated in the Evidence of Coverage.

Services or supplies related to **Hypnotism.**

Services or supplies because the Covered Person engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Evidence of Coverage, or which is **not Medically Necessary and Appropriate.**

Non-prescription drugs or supplies, except insulin needles and insulin syringes.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until Members have been covered by this Group Health Care Plan for six months. See the "Definitions" section of this Evidence of Coverage for the definition of a Pre-Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for A Member's Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which covered Member right before the Member's coverage under this Group Health Care Plan started, i.e., there is no intervening lapse in coverage.]

Any service provided without prior written Referral by the Member's **Primary Care Physician** except as specified in this Evidence of Coverage.

In the event of a Medical Emergency, the amount of any charge which is greater than a **Reasonable and Customary Charge.**

Services or supplies related to **rest or convalescent cures.**

Room and board charges for a Member in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Services or supplies related to **Routine Foot Care.**

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Member asserts his or her rights to obtain this coverage or payment for these services;

b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

c. for which a Member would not have been charged if he or she did not have health care coverage;

d. provided by or in a Government Hospital unless the services are for treatment:

- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Member's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Evidence of Coverage.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war,** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

VI. GRIEVANCE PROCEDURE

[Grievance Procedure: Variable by Carrier as approved by the State of New Jersey.]

VII. COORDINATION OF BENEFITS AND SERVICES

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision

A Member may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by this Group Health Care Plan as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange [or provide] with what another plan pays or provides. We do this so the Member does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;

b. group hospital or surgical plans, or other service or prepayment plans on a group basis;

c. union welfare plans, Employer plan, Employee benefits plans, trusted labor and management plans, or other plans for members of a group;

d. programs or coverages required by law;

e. group or group-type hospital indemnity benefits which exceed $250.00 per day;

f. group or group-type hospital indemnity benefits of $250.00 per day or less which the Employer pays part of the premium;

g. Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. group or group-type hospital indemnity benefits of $250.00 per day or less which the Employee pays the entire premium; nor

d. any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a Subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a Subscriber or Dependent under either this Group Health Care Plan or any other plan. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a Subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works

We apply this provision when a Subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first or provides services, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a. A plan that covers a person as a Subscriber pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a Subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a Subscriber whose birthday falls later in the Calendar Year pays second. The Subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a Subscriber.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver

We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under the Group Health Care Plan when services are incurred as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or

b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:

a. this Group Health Care Plan;

b. PIP; or

c. OSAIC.

"Eligible Services" means that of service provided for treatment of an Injury which is covered under this Group Health Care Plan without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

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

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

Determination of primary or secondary coverage

This Group Health Care Plan provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under this Group Health Care Plan. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another

automobile policy. This Group Health Care Plan may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selections regarding primacy of health coverage.

This Group Health Care Plan is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the {policyholder's} ***Contract Holder's*** plan. In that case this Group Health Care Plan will be primary.

If there is a dispute as to which policy is primary, this Group Health Care Plan will pay benefits or provide services as if it were primary.

Services this Group Health Care Plan will provide if it is primary to PIP or OSAIC.

If this Group Health Care Plan is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Group Health Care Plan will apply if:

- the Member is insured or covered for services under more than one insurance plan; and
- such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Group Health Care Plan will pay if it is secondary to PIP or OSAIC.

If this Group Health Care Plan is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or

b. the equivalent value of services if this Group Health Care Plan had been primary.

VIII. MEMBER GENERAL PROVISIONS

ASSIGNMENT

No assignment or transfer by a Member of any of his or her interest under this Group Health Care Plan is valid unless We consent thereto.

CONFIDENTIALITY

Information contained in the medical record of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Group Health Care Plan or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us may not be disclosed without the Member's written consent, except as required by law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Group Health Care Plan.

CONVERSION PRIVILEGE

If a Subscriber's Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

GOVERNING LAW

This entire Group Health Care Plan is governed by the laws of the State of New Jersey.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Group Health Care Plan is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Group Health Care Plan, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are Members. To be eligible for services or benefits under this Group Health Care Plan, the holder of the card must be a Member on whose behalf all applicable premium charges under this Group Health Care Plan have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Group Health Care Plan shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such Member and his or her Dependents, if any, pursuant to this Group Health Care Plan shall be terminated immediately, subject to the Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including, but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under this Group Health Care Plan, or similar causes, the rendition of medical or hospital benefits or other services provided under this Group Health Care Plan is delayed or rendered impractical. We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contract Holder or by a Member covered under this Group Health Care Plan shall be used in contesting the validity of his or her coverage or in deny benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

If the Contract replaces the contract of another insurer ***or carrier***, We may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from the Contract's Effective Date.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No Participating Provider or other provider, institution, facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any Participating Provider or other provider, institution, facility or agency.

2. Neither the Contract Holder nor any Member is our agent, representative or employee, or an agent or representative of any Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Group Health Care Plan.

3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.

4. No Contract Holder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Contract until 60 days after a Member files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

LIMITATION OF SERVICES

Except in cases of Medical Emergency, services are available only from Participating Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

MEDICAL NECESSITY

Members will receive designated benefits under the Group Health Care Plan only when Medically Necessary and Appropriate. We may determine whether any service or supply provided [or arranged] under the Group Health Care Plan was Medically Necessary and Appropriate, and We have the option to select the appropriate Participating Hospital to

render services if hospitalization is necessary. Decisions as to medical necessity are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Group Health Care Plan that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under this Group Health Care Plan.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to a Member: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide services and supplies to the extent stated in the Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Group Health Care Plan.

We reserve the right to modify or replace an erroneously issued Evidence of Coverage.

Information in a Member's application may not be used by Us to void the Contract or in any legal action unless the application or a duplicate of it is attached to the Contract or has been mailed to a Member.

CONTRACT INTERPRETATION

We shall administer Group Health Care Plan in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

REFERRAL FORMS

A Member can be referred for Specialist Services by a Member's Primary Care Physician.

Member will be responsible for the cost of all services provided by anyone other than a Member's Primary Care Physician (including, but not limited to, Specialist services) if a Member has not been referred by his or her Primary Care Physician.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor We, or any Participating Provider will have further responsibility to provide any of the benefits available under the Contract for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

REPORTS AND RECORDS

We are entitled to receive from any provider of services to Member such information We deem is necessary to administer this Group Health Care Plan subject to all applicable confidentiality requirements as defined in this Evidence of Coverage. By accepting coverage under this Group Health Care Plan, Subscriber, for himself or herself, and for all Dependents covered hereunder, authorizes each and every provider who renders services to the Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to Us upon request and to permit copying of a Member's records by Us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When You first obtain this coverage, You and each of Your covered Dependents must select a Primary Care Physician [or Health Center].

Members select a Primary Care Physician from Our [Physician or Practitioners Directory]; this choice is solely a Member's. However, We cannot guarantee the availability of a particular doctor. If the Primary Care Physician initially selected cannot accept additional patients, a Member will be notified and given an opportunity to make another Primary Care Physician selection.

[After initially selecting a Primary Care Physician, Members can transfer to different Primary Care Physicians if the physician-patient relationship becomes unacceptable. The Member can select another Primary Care Physician from Our [Physician or Practitioners Directory].

Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If we receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.]

STATEMENTS

No statement will void the coverage, or be used in defense of a claim under the Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the Member or to the Member's beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date he or she attains the Group Health Care Plan's age limit, or marries, or when a stepchild is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when Your coverage ends.

Read this Evidence of Coverage carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

THE ROLE OF A MEMBER'S PRIMARY CARE PHYSICIAN

A Member's Primary Care Physician provides basic health maintenance services and coordinates a Member's overall health care. Anytime a Member needs medical care, the Member should contact his or her Primary Care Physician and identify himself or herself as a Member of this program.

In a Medical Emergency, a Member may go directly to the emergency room. If a Member does, then the Member must call his or her Primary Care Physician and Member Services within 48 hours. If a Member does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

[THE ROLE OF THE CARE MANAGER. The Care Manager will manage a Member's treatment for a Mental or Nervous Disorder, Substance Abuse, or Alcohol Abuse. A Member must contact the Care Manager or the Member's Primary Care Physician when A Member needs treatment for one of these conditions.]

IX. CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Member may be eligible to continue his or her group health benefits under this Group Health Care Plan's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of this Group Health Care Plan at the same time.

Continuation Under CCR and NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR): If a Member is eligible to continue his or her group health benefits under both this Group Health Care Plan's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Group Health Care Plan:

If a Member elects to continue his or her group health benefits under both this Group Health Care Plan's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Member:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following **COBRA CONTINUATION RIGHTS** section may not apply to the Employer's plan. You must contact Your Employer to find out if:

a. the Employer is subject to the **COBRA CONTINUATION RIGHTS** section, and therefore;
b. the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Group Health Care Plan as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under the Group Health Care Plan during a continuation provided by this section is not a qualified continuee.

If Your Group Health Benefits Ends

If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:

a. You were not terminated due to gross misconduct; and
b. You are not entitled to Medicare.

The continuation:

a. may cover You and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from You by the Employer during this extra 11 month continuation period.

If You Die While Covered

If You die while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If Your Marriage Ends

If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Group Health Care Plan, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of You from Your spouse; or
b. the loss of dependent eligibility, as defined in this Group Health Care Plan, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his or her right to continue the Group Health Care Plan's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or
b. the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent's eligibility of a covered Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed {insured} ***covered*** under this Group Health Care Plan on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

c. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

e. the date the Contract ends;

f. the end of the period for which the last premium payment is made;

g. the date he or she becomes covered under any other Group Health Care Plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;

h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual {insurance policy} *contract*. Read this Evidence of Coverage's Conversion Rights for Divorced Spouses section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If Your Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then covered Dependents whose coverage would otherwise end at this time. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What You Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

The subsequent premiums must be paid to the Employer, by You, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed covered under this Group Health Care Plan on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under this Group Health Care Plan on a regular basis. Any modifications made under this Group Health Care Plan will apply to similarly situated continuees. We do not ask for evidence of good health in order for You to continue.

When Continuation Ends

A Member's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;

b. the date the Member becomes eligible for Medicare;

c. the end of the period for which the last premium payment is made;

d. the date the Member becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Member;

e. with respect to a Member who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Member, the date such limitation or exclusion ends;

f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or

g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Group Health Care Plan.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You are Totally Disabled

If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been covered by this Group Health Care Plan for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then covered Dependents.

How And When To Continue Coverage

To continue group health benefits, You must give the Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under this Group Health Care Plan would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, covered under this Group Health Care Plan on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay Us on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, Us.

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if You stop paying.

b. the date the Member becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;

c. the date this Group Health Care Plan ends or is amended to end for the class of Employees to which You belonged; or

d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Group Health Care Plan.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:

- the Employer must allow for a leave of absence uner Federal law and, therefore
- the section applies to You.

If Your Group Health Coverage Ends

Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your medical care coverage will be continued. Dependents' coverage may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Coverage may continue until the earliest of:

a. the date You return to Full-Time work

b. the end of a total period of 12 weeks in any 12 month period, or

c. the date on which Your coverage would have ended had You not been on leave.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were covered under this Group Health Care Plan may elect to continue coverage. Subject to the payment of the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of Your death; or

b. the date the Dependent is no longer eligible under the terms of this Group Health Care Plan.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF YOUR MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual {policy} ***contract*** during the conversion period. The former spouse may cover under his or her individual {policy} ***contract*** any of his or her Dependent children who were covered under this Group Health Care Plan on the date the group health coverage ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

- unless he or she has been {insured} ***covered*** under this Group Health Care Plan for at least 3 months;
- if he or she is eligible for Medicare;
- if it would cause him or her to be {overinsured} ***excessively covered***; or

[• if he or she permanently relocates outside the Service Area.]

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will determine if {overinsurance} ***excessive coverage*** exists using Our standards for {overinsurance} ***excessive coverage***.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual {policy} ***contract*** in writing and pay the first premium for such {policy} ***contract*** during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT

The individual {policy} ***contract*** will provide the medical benefits that We are required to offer. The individual {policy} ***contract*** will take effect on the day after group health coverage under this Group Health Care Plan ends.

After group health coverage under this Group Health Care Plan ends, the former spouse and any children covered under the individual {policy} ***contract*** may still {be paid} ***receive*** benefits under this Group Health Care Plan. If so, benefits to be paid under the individual {policy} ***contract, if any,*** will be reduced by the amount paid or the reasonable cash value of services provided under this Group Health Care Plan.

X. RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, {insured} ***covered*** by this Contract.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us under this Group Health Care Plan prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;

b. a satisfied judgment; or

c. other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or

b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Group health Care Plan or arrange [or provide] services and supplies to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

XII. EFFECT OF MEDICARE ON THE COVERAGE

A. ELIGIBILITY PROVISIONS FOR MEMBERS ARE 65 OR MORE WHO ARE ELIGIBLE FOR MEDICARE.

"Medicare means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

"Part A of Medicare" means the program of Hospital Insurance for the Aged and Disabled under Part A of Medicare.

A Member age 65 or more who is eligible for Part A of Medicare may have this coverage as that person's primary benefit program, pursuant to the Federal Age Discrimination in Employment Act, as amended. The coverage for such Member will continue only while the Member is meeting the following conditions:

(1) In the case of an Employee, the Employee is not retired.

(2) In the case of a Dependent, the Member is the Dependent of an Employee who meets condition (1) above.

(3) The Member has not elected Medicare, in writing, as the primary benefit program.

B. SPECIAL PROVISIONS FOR OTHER MEMBERS WHO ARE ELIGIBLE FOR MEDICARE.

For a Member who is eligible for Medicare and to whom section A above does not apply, this coverage will continue only subject to the following conditions:

(1) The Member, if eligible, has enrolled in Parts A and B of Medicare.

(2) The Member has completed such consents, releases, assignments and other documents reasonably requested by Us to obtain or assure Medicare reimbursements.

C. SERVICES AND SUPPLIES.

The services and supplies of this coverage provided to Members are not designed to duplicate any benefit for which they are enrolled and entitled

under Medicare. All sums payable under Medicare for services and supplies that are provided under this coverage will be payable to, and retained by, Us.

EXHIBIT Z
PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD/MAIL)

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled. "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is **not** obtained through the Mail Order Program is:

- for Generic Drugs $ 5.00
- for Brand Name Drugs $10.00

The Co-Payment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Drugs NONE
- for Brand Name Drugs $5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);

b. dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and

c. needed to treat an Illness or Injury or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;

b. a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and

c. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.

b. Charges for:

- immunization agents
- biological sera
- blood or blood plasma.

c. Charges for a Prescription Drug which is:

- labeled "Caution—limited by Federal Law to investigational use"; or
- experimental.

d. Charges for refills in excess of that specified by the prescribing Practitioner.

e. Charges for refills dispensed after one year from the original date of the prescription.

f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:

- a Hospital
- a rest home

- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

h. Charges for:

- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i. Charges for vitamins, except Legend Drug vitamins.

j. Charges for drugs containing nicotine or other smoking deterrent medication.

k. Charges for topical dental Fluorides.

l. Charges for any drug used in connection with baldness.

m. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.

n. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

o. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.

p. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.

q. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

EXHIBIT Z
PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD)

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

• for Generic Drugs	$ 5.00
• for Brand Name Drugs	$10.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);

b. dispensed by a Participating Pharmacy; and

c. needed to treat an Illness or Injury or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. the greater of a 30 day supply or 100 unit doses; and

b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.

b. Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c. Charges for a Prescription Drug which is:
- labeled "Caution—limited by Federal Law to investigational use"; or
- experimental.

d. Charges for refills in excess of that specified by the prescribing Practitioner.

e. Charges for refills dispensed after one year from the original date of the prescription.

f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

h. Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i. Charges for vitamins, except Legend Drug vitamins.

j. Charges for drugs containing nicotine or other smoking deterrent medication.

k. Charges for topical dental Fluorides.

l. Charges for any drug used in connection with baldness.

m. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.

n. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

o. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.

p. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.

q. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

EXHIBIT Z
PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE (MAIL)

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

• for Generic Drugs	None
• for Brand Name Drugs	$5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by

a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);

b. dispensed by a Participating Mail Order Pharmacy for take-home use; and

c. needed to treat an Illness or Injury or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and

b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.

b. Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c. Charges for a Prescription Drug which is:
- labeled "Caution—limited by Federal Law to investigational use"; or
- experimental.

d. Charges for refills in excess of that specified by the prescribing Practitioner.

e. Charges for refills dispensed after one year from the original date of the prescription.

f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

h. Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i. Charges for vitamins, except Legend Drug vitamins.

j. Charges for drugs containing nicotine or other smoking deterrent medication.

k. Charges for topical dental Fluorides.

l. Charges for any drug used in connection with baldness.

m. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.

n. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

o. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.

p. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.

q. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

EXHIBIT Z
PART 4

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, or Mental and Nervous Conditions and Substance Abuse which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness, Injury or Mental and Nervous Conditions and Substance Abuse by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

The **Mental and Nervous Conditions and Substance Abuse** section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and precertifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply

with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the **Penalty for Non-Compliance with Pre-Certification Requirements** section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment **must** be reviewed by [XYZ] **before** it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non-emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

a. the Medical Necessity and Appropriateness;
b. the type of service involved;
c. the appropriate level of care required; and
d. the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [$150] for each day of Inpatient care up to a maximum of [$750] per confinement, subject to a maximum of [$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [$15.] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co-Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:

a. 30 days of Inpatient care per Calendar Year; and
b. 20 Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

a. the Covered Person does not request a review in the times and manner described above;
b. the Covered Person's treatment does not comply with the treatment plan;
c. the Covered Person goes to a Provider whose services were not referred by [XYZ]; or
d. [XYZ] does not confirm the need for such care or treatment.

APPEALS PROCEDURE

[If the Covered Person or his or her attending Practitioner does not agree with the outcome of the [XYZ] review, the case will be immediately referred to a [XYZ] Practitioner who will discuss the case directly with the attending Practitioner. If an agreement is not reached, the case will be internally reviewed by a staff psychiatrist who may request that a local case manager see the Covered Person, or may discuss the case again with the attending Practitioner. This may involve a visit to the Facility in question and a clinical interview with the Covered Person and/or the family. If there is not agreement at that time, the Covered Person may appeal directly to [Carrier].]

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

EXHIBIT AA
PART 1

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE **(CARD/MAIL)**

Contract Holder:

Group Contract No.

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

In no event will We provide [or arrange] for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; and
b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Member can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Member must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is **not** obtained through the Mail Order Program is:

- for Generic Drugs $ 5.00
- for Brand Name Drugs $10.00

The Co-Payment for each prescription or refill which is obtained through the Mail-Order Program is:

- for Generic Drugs None
- for Brand Name Drugs $5.00

After the Co-Payment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);

b. dispensed by a Participating Pharmacy; and

c. needed to treat an Illness or Injury or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;

b. a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and

c. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription Drug.

b. Immunization agents.

c. Biological sera.

d. Blood or Blood Plasma.

e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use"; or experimental.

f. Refills in excess of the amount specified by the prescribing Participating Provider.

g. Refills dispensed after one year from the original date of the prescription.

h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.

i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- a Skilled Nursing Center
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.

k. Vitamins, except for Legend Drug vitamins.

l. Drugs containing nicotine or other smoking deterrent medication.

m. Topical dental Fluorides.

n. Drugs used in connection with baldness.

o. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.

p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

q. Drugs dispensed to a Member while on active duty in any armed force.

r. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

s. Drugs needed due to an on-the-job or job-related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure.]

EXHIBIT AA
PART 2

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE (CARD)

Contract Holder:

Group Contract No.

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information.

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

In no event will We provide for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin, insulin needles and insulin syringes; and

d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Member must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

• for Generic Drugs	$ 5.00
• for Brand Name Drugs	$10.00

After the Co-Payment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);

b. dispensed by a Participating Pharmacy; and

c. needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription Drug.

b. Immunization agents.

c. Biological sera.

d. Blood or Blood Plasma.

e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use"; or experimental.

f. Refills in excess of the amount specified by the prescribing Participating Provider.

g. Refills dispensed after one year from the original date of the prescription.

h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.

i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- a Skilled Nursing Center
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.

k. Vitamins, except for Legend Drug vitamins.

l. Drugs containing nicotine or other smoking deterrent medication.

m. Topical dental Fluorides.

n. Drugs used in connection with baldness.

o. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.

p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

q. Drugs dispensed to a Member while on active duty in any armed force.

r. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

s. Drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure.]

EXHIBIT AA
PART 3

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE **(MAIL)**

Contract Holder:

Group Contract No.

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information.

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

In no event will We provide [or arrange] for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Member can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Member must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is:

- for Generic Drugs None
- for Brand Name Drugs $5.00

After the Co-Payment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);

b. dispensed by a Participating Mail Order Pharmacy; and

c. needed to treat an Illness or Injury or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than:

a. a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and

b. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription Drug.

b. Immunization agents.

c. Biological sera.

d. Blood or Blood Plasma.

e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use"; or experimental.

f. Refills in excess of the amount specified by the prescribing Participating Provider.

g. Refills dispensed after one year from the original date of the prescription.

h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.

i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- a Skilled Nursing Center
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.

k. Vitamins, except for Legend Drug vitamins.

l. Drugs containing nicotine or other smoking deterrent medication.

m. Topical dental Fluorides.

n. Drugs used in connection with baldness.

o. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.

p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

q. Drugs dispensed to a Member while on active duty in any armed force.

r. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

s. Drugs needed due to an on-the-job or job-related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure.]

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

Notice of Administrative Correction to Notice of Adoption for N.J.A.C. 13:35-10
Athletic Trainers

Take notice that the State Board of Medical Examiners has discovered that the response to the second comment that appeared in the New Jersey Register on November 1, 1993, at 25 N.J.R. 4935(a) regarding the role of the athletic trainer in light of the Orthotist and Prosthetist Licensing Act P.L. 1993, c.512 (N.J.S.A. 45:12B-1 et seq.) was incorrect; athletic trainers are not exempt under the Act.

A joint committee will be formed to consider the impact of the Orthotist and Prosthetist Licensing Act on athletic trainers.

This notice is published in accordance with N.J.A.C. 1:30-2.7.

(a)

DIVISION OF CRIMINAL JUSTICE

Office of the State Medical Examiner

Readoption with Amendments: N.J.A.C. 13:49

Proposed: November 15, 1993 at 25 N.J.R. 5104(a).
Adopted: December 16, 1993 by Robert Goode, M.D., State Medical Examiner.
Filed: December 16, 1993 as R.1994 d.30, **without change.**

Authority: N.J.S.A. 52:17B-80.

Effective Date: December 16, 1993, Readoption,
January 18, 1994, Amendments.
Expiration Date: December 16, 1998.

The State Medical Examiner Office afforded all interested persons with an opportunity to provide written comments on the readoption with amendments of N.J.A.C. 13:49. These rules provide standards and procedures for the State and county medical examiners in exercising their statutory authority. They also provide for training and experience requirements of county medical examiners, their deputies or assistants and forensic pathologists. Announcement of the opportunity to comment on the proposed readoption with amendments appeared in the New Jersey Register on November 15, 1993 at 25 N.J.R. 5104(a). Secondary notice of the proposed amendments was provided to all county medical examiners and county prosecutors, the State Department of Health and the Poison Control Center.

The State Medical Examiner received three comments in response to the proposed readoption with amendments. A summary of the comments and this agency's response follows:

COMMENT: Dr. Steven M. Marcus, the regional director of the Poison Control Center (PCC), suggested that the PCC receive pertinent autopsy reports in a timely manner in the event a medical examiner needs to consult with the Center.

RESPONSE: The agency responds that the amendments do not impose any limitations on consultation between a medical examiner and the PCC in cases where it is appropriate to do so. The purpose of the readoption is to ensure quality of services in post-mortem examinations and reliability of homicide investigations. To that end, the State Medical Examiner Office will continue to work cooperatively with the PCC. In the opinion of the agency, the comment does not require further amendment of the proposed readoption.

COMMENT: Paul R. Langevin, Jr., Acting Deputy Commissioner for the New Jersey Department of Health, commented on his interpretation of the proposed readoption as they affect health facilities' access to medical examiner records. He opined that N.J.A.C. 13:49-3.1(a) is not meant to be interpreted as a basis for non-disclosure of any portion of the Report of Investigation by Medical Examiner (RIME) or the autopsy or related medical reports; that N.J.A.C. 13:49-3.1(b)2 and 3 should not block physicians' and hospitals' access to medical examiner reports in that hospitals and physicians are required by law to protect patients' records; and that parties presumed to have a proper interest in medical examiner records under N.J.A.C. 13:49-3.1(c) include the staff of trauma centers, burn units and poison control centers who assisted in the care of injured patients that died. He also questioned whether the New Jersey State Department of Health should be added to the list of parties presumed to have a proper interest in medical examiner records under N.J.A.C. 13:49-3.1(c).

RESPONSE: The agency responds that Dr. Siegel's comments concerning the readoption are consistent with the agency's interpretation. The purpose of N.J.A.C. 13:49-3.1(b) is to permit the release of medical examiner records which are required by law to be made, maintained or kept consistent with New Jersey's Right to Know Act. Other common law records may be released in the discretion of the State Medical Examiner and are presumed to be available to appropriate medical personnel. See N.J.A.C. 13:49-3.1(c). N.J.A.C. 13:49-3.1(b)2 and 3 merely state existing law and, unless precluded by such laws, physicians and hospitals will, as always, continue to have access to medical examiner records. N.J.A.C. 13:49-3.1(c) specifically provides that physicians who assisted in the care of injured patients that died will have access to medical examiner records. This includes members of medical staffs of State designated Level I or Level II trauma centers, burn units, and poison control units. The Department of Health is presumed to have a proper interest in medical examiner records to the extent that they are encompassed by both the statutory and common law right to know laws. See N.J.A.C. 13:49-3.1(a), (b), and (c). In the opinion of the agency, the comments do not require further amendment of the proposed readoption.

COMMENT: Jeffrey Hammond, M.D., Section Chief, Trauma/Surgical Critical Care and Chairman of Trauma Center Council at the University of Medicine and Dentistry (UMDNJ), asked for clarification that N.J.A.C. 13:49-3.1(c) allows for the release of information to trauma surgeons at the Level I and Level II trauma centers.

RESPONSE: The agency responds that the proposed amendments allow for the release of information to trauma surgeons at Level I and Level II trauma centers, as described in the prior response. Therefore, no further amendment of the proposed readoption is necessary.

No further comments were received by the agency as a result of the public notice of the proposed readoption in the New Jersey Register and the distribution list.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 13:49.

Full text of the adopted amendments follows:

13:49-1.2 Discretionary autopsies

In the absence of an objection based on the religious beliefs of the decedent, autopsies may be performed when it appears in the discretion of the county medical examiner to be in the public interest to do so in all cases of human deaths occurring in the following circumstances:

1.-2. (No change.)

3. All deaths of inmates as defined in N.J.S.A. 52:17B-86(f) occurring in institutions maintained in whole or in part at the expense of the State or county when the inmate was not hospitalized therein for organic disease;

4.-5. (No change.)

13:49-1.7 Medical examiner's investigative standards for unidentified decedents

(a)-(e) (No change.)

(f) In any event, an NCIC entry shall be made no later than seven days following completion of the autopsy incorporating all features of identification, including estimations of age, time of death, height, sex, race, any known medical conditions discovered by autopsy, and a full description of clothing and personal effects. The Unidentified Person File Data Collection Entry Guide may be used as an aid.

(g)-(i) (No change.)

13:49-2.1 Collection of specimens for alcohol determinations

(a) Whenever the county medical examiner, or the person designated by the State Medical Examiner or county medical examiner to conduct investigations and perform autopsies in a county, conducts an autopsy pursuant to N.J.S.A. 52:17B-88 et seq., that person shall collect suitable specimens for determination of the alcohol content of the blood and brain tissue in all cases of violent death or death under unusual circumstances where death has occurred within 48 hours of the incident suspected of being the proximate cause of death.

(b) (No change.)

13:49-2.2 Collection of specimens for narcotic or dangerous drug determination

(a) Whenever the county medical examiner, or the person designated by the State Medical Examiner or county medical examiner to conduct the investigations and perform autopsies in a county, conducts an autopsy pursuant to N.J.S.A. 52:17B-88 et seq., that person shall collect suitable specimens for determination of the drug content of the body fluids and tissues in all cases of violent deaths or deaths under unusual circumstances where death has occurred within 48 hours of the incident suspected of being the proximate cause of death.

(b) (No change.)

13:49-3.1 Release of records

(a) The records that are required by law to be made, maintained or kept by the County or State Medical Examiner are the Report of Investigation by Medical Examiner, the inventory of property of

value, the autopsy report, including its findings and conclusions, and the results of external examinations upon the bodies of deceased persons. Not included within this definition are any records or portions thereof which contain opinions, subjective evaluations or critical analyses.

(b) The medical examiner shall, upon request, make available for inspection during regular business hours the records required to be made, maintained or kept as defined by (a) above and shall produce copies of the requested records upon payment of such reasonable fee as may be provided by this chapter, except as otherwise provided by:

1. The Right to Know Law, N.J.S.A. 47:1A-1 et seq.;

2. Laws covering confidentiality of records such as the AIDS Assistance Law, N.J.S.A. 5C-1 et seq.;

3. Any other law requiring confidentiality of records;

4. The status of an ongoing investigation as defined by Executive Order No. 123(1985); or

5. Whenever medical examiner's records are not yet complete.

(c) Any other records that satisfy the common law definition of a "public record" which may exist in the medical examiner's file may be inspected or copied with the exceptions as noted above in (b) provided the requestor is able to demonstrate that his or her particular interest outweighs the need of the agency and/or the public interest in confidentiality. The propriety of the party's interest in these records shall be determined by the authorized county medical examiner in consultation with the State Medical Examiner whose final determination shall be binding. The next of kin of the decedent, immediate family members, physicians who treated the decedent for his or her last illness or injury, the decedent's legal representative, law enforcement agencies, or attorneys or insurance companies representing parties in litigation arising from the incident that caused the decedent's death are presumed to have a proper interest in these records.

(d) In the event that the requestor is unable to demonstrate a proper interest, the County or State Medical Examiner may advise the requestor to seek a court ordered release of records.

(e) Notwithstanding (b) and (c) above, if the death has been referred to the county prosecutor or Attorney General for continuing criminal investigation, only the county prosecutor or Attorney General may disclose the autopsy findings. When a party seeks the autopsy report in connection with pending or future criminal litigation, the county prosecutor or Attorney General shall provide the report through the discovery process, in accordance with court rules, or before discovery is undertaken if the prosecutor or Attorney General deems it appropriate.

(f) Notwithstanding (c) and (d) above, the autopsy report may be furnished to any person upon written authority of the decedent's next of kin or legal representative, unless the death has been referred to the county prosecutor or Attorney General for continuing criminal investigation.

13:49-3.3 Filing of Reports

(a)-(c) (No change.)

(d) The description and report of gross autopsy findings shall be completed, signed by the physician, and delivered to the county prosecutor and the State Medical Examiner within 30 days of completion of gross dissection.

(e)-(f) (No change.)

(g) All original signed documents to include the Report of Investigation by Medical Examiner, supplemental investigative reports, autopsy reports and amendments thereto, shall be maintained a minimum of five years as paper documents and on microfilm permanently thereafter. Any photographing, microphotographing and microfilming shall be in accord with N.J.S.A. 47:3-26.

13:49-5.1 Death investigations; conduct

(a)-(f) (No change.)

(g) Whenever the county medical examiner, or the person designated by the State Medical Examiner or county medical examiner to perform autopsies in a county, conducts an autopsy pursuant to N.J.S.A. 52:17B-88 et seq. on a decedent who has been treated in a hospital following an incident of external violence, the examiner shall obtain from the hospital any specimens that may have been obtained or removed from the decedent for analysis during the course of diagnosis or treatment where death has occurred within 48 hours of the incident suspected of being the proximate cause of death.

Recodify existing (g) and (h) as (h) and (i) (No change in text.)

13:49-6.2 Notification of death from contagious, infectious, or communicable diseases

(a)-(b) (No change.)

(c) Whenever the medical examiner establishes a new diagnosis or confirms a suspected diagnosis of Human Immunodeficiency Virus (HIV) infection by autopsy, he or she shall complete the HIV Confidential Case Report of the New Jersey Department of Health, and forward it to:

New Jersey Department of Health
CN 363
Trenton, New Jersey 08625-0363

13:49-7.1 Eligibility standards of county medical examiner, deputy or assistant county medical examiner, and forensic pathologist

(a)-(c) (No change.)

(d) Only those county medical examiners, deputy or assistant county medical examiners or forensic pathologists authorized by the State Medical Examiner as competent to perform autopsies pursuant to N.J.S.A. 52:17B-88, shall perform such autopsies. Such person shall be qualified in one of the following categories:

1. Pathologists who shall have completed a two-year program of supervised training in anatomical pathology approved by the Accreditation Council for Graduate Medical Education of the American Medical Association are eligible to conduct death investigations and to perform postmortem examinations and autopsies under the direct guidance and supervision of a designated pathologist who has already been qualified to practice in an unsupervised capacity in the New Jersey Medical Examiner System, pursuant to (d)2 below and under the general supervision of the State Medical Examiner as provided by law. The reports prepared by this person shall be countersigned by the designated pathologist who has supervised the autopsy.

2. Pathologists who qualify as anatomic pathologists as defined in (d)1 above, and who have at least one year of formal supervised training in a forensic pathology program approved by the Accreditation Council for Graduate Medical Education, or two years supervised experience in forensic pathology in a situation comparable with that of a program accredited by the Accreditation Council for Graduate Medical Education are eligible to conduct death investigations and to perform postmortem examinations and autopsies under the general supervision of the State Medical Examiner as provided by law.

3. Physicians of any speciality who, by virtue of their experience in a medical examiner system, are able to produce a portfolio of personal case studies acceptable to the State Medical Examiner and who, further, are able to demonstrate by interview a knowledgeable approach to forensic problems may be declared eligible to conduct death investigations and to perform postmortem examinations and autopsies under the general supervision of the State Medical Examiner as provided by law.

(e) (No change.)

OTHER AGENCIES

(a)

CASINO CONTROL COMMISSION

General Provisions
Definitions
Communications; Notices
Hearings
Casino Licensees
Internal Controls
Persons Doing Business with Casino Licensees
Taxes

Adopted Amendments: N.J.A.C. 19:40-1.2 and 3.3, 19:42-1,1, 19:43-13.1, 19:45-1.1, 19:51-1.1 and 19:54-1.2

Proposed: November 1, 1993 at 25 N.J.R. 4866(a).
Adopted: December 16, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: December 20, 1993 as R.1994 d.31, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 5:12-63c and 69a.

Effective Date: January 18, 1994.
Expiration Dates: N.J.A.C. 19:40, August 24, 1994; N.J.A.C. 19:42, April 15, 1995; N.J.A.C. 19:43, December 21, 1997; N.J.A.C. 19:45, August 15, 1997; N.J.A.C. 19:51, April 27, 1994 and N.J.A.C. 19:54, December 15, 1994.

Summary of Public Comments and Agency Responses:
Comments were received from the Division of Gaming Enforcement ("Division") and the Sands Hotel & Casino ("the Sands").

COMMENT: The Division noted that N.J.A.C. 19:40-3.3, Communications; notices, is a general notice provision, and as such should expressly refer to "registrants" as well as "applicants and licensees."

RESPONSE: The Commission agrees and appropriate references are added upon adoption.

COMMENT: The Sands commented that the "new" definition of a "pit" at N.J.A.C. 19:40-1.2 "does not admit the customary practice in poker, where the patrons are located both within [and] on the outside perimeter of the pit area."

RESPONSE: The amendments herein simply recodify the current definition of a "pit"; no new or revised language was proposed. Such definition does not require amendment to address the conduct of poker, which is regulated by proposed N.J.A.C. 19:47-14. See proposed N.J.A.C. 19:47-14.6(a), which provides that "poker shall be conducted in a separate and distinct area of the casino floor or casino simulcasting facility."

Full text of the adoption follows (additions to the proposal indicated in boldface with asterisks ***thus***; deletions from the proposal indicated in brackets with asterisks *[thus]*):

19:40-1.2 Definitions

(a) The following words and terms are defined in the New Jersey Casino Control Act (P.L. 1977, c.110, as amended) and are used in these rules as defined in that Act:

"Applicant"
"Application"
"Authorized game" or "authorized gambling game"
"Casino"
"Casino employee"
"Casino hotel employee"
"Casino hotel security employee"
"Casino key employee"
"Casino license"
"Casino security employee"
"Casino service industry"
"Commission"
"Complimentary service or item"
"Conservator"
"Creditor"
"Debt"
"Director"
"Division"
"Encumbrance"
"Equal employment opportunity"
"Equity security"
"Family"
"Game" or "gambling game"
"Gaming" or "gambling"
"Gaming device" or "gaming equipment"
"Gross revenue"
"Hearing examiner"
"Holding company"
"Hotel" or "approved hotel"
"Intermediary company"
"Junket"
"Junket enterprise"
"Junket representative"
"License"
"License or registration fee"
"Licensed casino operation"
"Licensee"
"Operation"
"Party"
"Person"
"Principal employee"
"Property"
"Publicly traded corporation"
"Registrant"
"Registration"
"Regulated complimentary service account"
"Resident"
"Respondent"
"Restricted casino areas"
"Security"
"Slot machine"
"Statement of compliance"
"Subsidiary"
"Transfer"

(b) The following words and terms, when used in these rules, shall have the following meanings, unless the context clearly indicates otherwise.

"Act" or "Casino Control Act" means the New Jersey Casino Control Act (P.L. 1977, c.110, as amended).

...

"Casino licensee" or "licensed casino" means the holder of any license issued pursuant to the Casino Control Act, that authorizes the ownership or operation of a casino or casino simulcasting facility.

...

"Contested case" means a proceeding, including any licensing proceedings, in which the legal rights, duties, obligations, privileges, benefits or other legal relations of specific parties are required by constitutional right or by statute to be determined by an agency by decisions, determinations, or orders, addressed to them or disposing of their interests, after opportunity for an agency hearing.

"Establishment" means a casino hotel complex, meeting the requirements of the Casino Control Act, wherein gaming is conducted or gaming devices are used in connection with gaming.

...

"Interested person" means any person whose specific legal rights, duties, obligations, privileges, benefits or other specific legal relations are affected by the adoption, amendment or repeal of a specific regulation or by any decision, order or ruling of the Commission.

...

"Operation certificate" means a certificate issued by the Commission which certifies that operation of a casino and, if applicable, of a casino simulcasting facility conforms to the requirements of the Act and applicable regulations and that its personnel and procedures are efficient and prepared to entertain the public.

...

"Pari-mutuel window" is defined in N.J.A.C. 19:45-1.14A(b)1.

...

"Pit" means the area enclosed or encircled by the arrangement of gaming tables in which casino personnel administer and supervise the games played at the tables by the patrons located on the outside perimeter of the area.

...

19:40-3.3 Communications; notices

(a)-(b) (No change.)

(c) Except as otherwise specifically provided by law or Commission regulations, notices and other communications from the Commission or Division will be sent to an applicant *[or]* *,* licensee ***or registrant*** by either ordinary mail or certified mail to the address shown in the most recent application or change of address notice received from such person; or, in the case of a casino licensee, by depositing such notices and other communications in the appropriate mail slot designated for each casino licensee in the Commission mailroom. Such notices and communications will be available for pickup by casino licensees from 9:00 A.M. to 5:00 P.M. in the Commission mailroom located at:

Arcade Building, 1st Floor
Tennessee Avenue and Boardwalk
Atlantic City, New Jersey 08401

(d) Notices shall be deemed to have been served upon their deposit, postage prepaid, in the United States mails, or upon their deposit in the Commission mailroom in the designated mail slot for each casino licensee, and the time specified in any such notice shall commence to run from that date.

(e) Any applicant *[or]* *,* licensee ***or registrant*** who desires to have notices or other communications mailed to an address other than that specified in the application shall file with the Commission and the Division a specific request for that purpose, and notices and other communications will, in such case, be sent to the applicant *[or]* *,* licensee ***or registrant*** at such address.

(f) An applicant *[or]* *,* licensee ***or registrant*** will be addressed under the name and style designated in the application, and separate notices or communications will not be sent to individuals named in such application unless a specific request for that purpose is filed with the Commission and the Division. In the absence of such a specific request, a notice addressed under the name or style designated in the application shall be deemed to be notice to all individuals named in such application.

(g) Applicants *[and]* *,* licensees ***and registrants*** shall immediately notify the Commission and the Division of any change of address, and shall specifically request that all notices or other communications be sent to the new address.

19:42-1.1 Definitions

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

19:43-13.1 Definitions

The following words and terms are defined in the New Jersey Casino Control Act (P.L. 1977, c.110, as amended) and are used in this subchapter as defined in that Act:

"Conservatorship action"

19:45-1.1 Definitions

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

...

"Verbalize" means to orally express something in words.

...

19:51-1.1 Definitions

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

...

19:54-1.2 Definitions

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

...

(a)

CASINO CONTROL COMMISSION

Exclusion of Persons

Adopted Amendments: N.J.A.C. 19:42-4.5 and 19:48-1.1, 1.3, 1.4, 1.7 and 1.8

Adopted Repeal and New Rule: N.J.A.C. 19:48-1.5

Proposed: October 18, 1993 at 25 N.J.R. 4739(a).
Adopted: December 16, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: December 20, 1993 as R.1994 d.32, **without change.**

Authority: N.J.S.A. 5:12-63c, 69a, 70b, 70d and 71.

Effective Date: January 18, 1994.
Expiration Date: N.J.A.C. 19:42, August 15, 1995;
N.J.A.C. 19:48, August 15, 1998.

Summary of Public Comments and Agency Responses:

Comments were received from the Division of Gaming Enforcement (Division). No other comments were received.

COMMENT: The Division suggested that the exclusion criteria be amended to provide for the exclusion of members or associates of an organized crime family. The Division's position is that such an amendment would harmonize the exclusion criteria with disqualification criteria set forth in N.J.S.A. 5:12-86f, make criteria consistent with terminology used in law enforcement agencies, and conform the regulations to Commission practice.

RESPONSE: The regulatory exclusion criteria supplement the statutory exclusion criteria in section 71a with an individual "who is an associate of a career or professional offender." N.J.A.C. 19:48-1.3(a)2. Such an individual is an associate of a "career offender cartel," as that term is used and defined for purposes of licensure disqualification in section 86f of the Act. The Commission has throughout its history consistently deemed a member or an associate of a crime family to be "an associate of a career offender." Without derogating the construction and language of section 71 which neither uses nor refers to "career offender cartel," the regulation, as originally created, appropriately parallels the statutory differences between licensure criteria and exclusion criteria.

COMMENT: The Division proposes to include in exclusion criteria, under N.J.A.C. 19:48-1.3(a)3, criminal convictions from any jurisdiction. This would conform the exclusion standard to the licensure standard for disqualifying convictions set forth at N.J.S.A. 5:12-86c(1). The Division notes the expected influx into the United States of criminals from abroad within the next few years, and the derivative expectation that they will frequent casinos in Atlantic City. Because the regulation, by its present terms, does not encompass persons with convictions from foreign jurisdictions, law enforcement objectives will be impeded.

RESPONSE: This modification would unduly expand the scope of the excluding convictions beyond the statutory parameters of section 71a(2), which provides the exclusion standard for persons "[w]ho have been convicted of a criminal offense **under the laws of any state or of the United States**, which is punishable by more than 6 months in prison . . .". [Emphasis added.] As a practical matter, it should be noted that this criterion is rarely the exclusive basis on which the Division seeks to exclude a person. More typically, the Division joins other criteria in a petition to exclude.

While the Division analogizes licensing criteria under section 86c(1) of the Act to exclusion criteria, it must be presumed that the Legislature acted purposefully in enacting the distinct language in each section. The statutory cut-off for an offense punishable by more than six months imprisonment is a term of demarcation between a "felony" and a "misdemeanor" under federal constitutional law in determining a criminal defendant's right to a trial by jury. Moreover, to recognize convictions in foreign jurisdictions on equal terms with convictions in American federal and state courts may deride certain revered tenets of our criminal

jurisprudence (e.g., presumption of innocence and proof of guilt beyond a reasonable doubt). Thus, to amend the regulation to include convictions under the laws of any jurisdiction would supplant a legislative prerogative. If the jurisdictional distinction does not or no longer serves a useful purpose, the recourse is legislative.

COMMENT: The Division excepts to the new regulation, at N.J.A.C. 19:48-1.4(c), compelling it to file an exclusion petition whenever it files a complaint under section 71d against a licensee(s). The Division suggests that the Commission may determine not to entertain a section 71d complaint if the Division does not file a petition to exclude. The Division claims that the proposal does not countenance the prospect that a 71d complaint would be barred if the excludable person dies or is sentenced to a long prison term before it files a section 71d complaint.

RESPONSE: The genesis of N.J.A.C. 19:48-1.4(c) is a complaint filed by the Division under section 71d of the Act. In adjudicating the matter, the Commission was placed in the awkward position of determining a person's excludability from Commission-regulated premises without affording that person an opportunity to be heard. The Division opted to try the issue of a person's excludability in the context of complaints against third party licensees. Such a result is not consonant with the due process procedures established for Division-initiated exclusion petitions. Moreover, determining a person "excludable" yields the anomalous and unpalatable result of "selective exclusion;" that is, the person is *persona non grata* at only the licensed facilities which have reason to know that he or she may satisfy exclusion criteria, but not necessarily at other licensed facilities which may not. Proposed N.J.A.C. 19:48-1.4(c) redresses these problems without treading on the prosecutorial prerogative of the Division.

It is not the province of the Commission to regulate the Division. It is, however, the province of the Commission to establish procedural rules affecting practice before it. The Commission has established a corollary procedural rule governing the filing of exclusion petitions in the customary manner. Under N.J.A.C. 19:48-1.4(b), if the Division determines that an individual should be placed on the exclusion list, the Division shall file a petition for exclusion with the Commission, identifying the candidate and setting forth the factual basis for the Division's determination. The proposed procedural rule directs the Division in no different a manner when it files a section 71d complaint.

The Division suggests that the Commission may determine not to entertain a section 71d complaint if the Division does not file a petition to exclude. The Commission should not be placed in the position of discouraging well-founded section 71d actions at the expense of its primary obligation under section 71—placing on the exclusion list persons who satisfy exclusion criteria. Only then should the Commission be asked to visit liability on casino or employee licensees for not fulfilling their companion duty under section 71d.

The Division claims that the proposal does not countenance the prospect that a 71d complaint would be barred if the excludable person dies or is sentenced to a long prison term before it files a section 71d complaint. There is nothing to preclude the Division from making the averment of the death of the person it believes satisfied exclusion criteria in its section 71d complaint, which would moot, as a matter of law, the joint/contemporaneous filing requirement of the proposed regulation. A long term prison sentence, in all cases, is the presumptive result of a *per se* excluding conviction. To establish this fact would not unduly waste regulatory resources.

COMMENT: The Division suggests the imposition of a one-year bar on removal petitions contrary to proposed N.J.A.C. 19:48-1.8(d) which provides that a removal petition may be filed at any time, but only once during the five years after a final order of exclusion is entered. To do so would make removal from the exclusion list consistent with reapplication for licensure.

RESPONSE: Under N.J.A.C. 19:41-8.8, a person whose credential is revoked or whose application is denied may be eligible to reapply at any time after one year from the date of revocation or denial. The proposal is, in essence, a more liberal re-entry provision for excluded persons than for persons prohibited from holding working credentials. In not imposing a time bar for a petition to remove a person from the exclusion list, the Commission accords recognition to the distinction between regulating privileges of casino employees to work in the casino industry and the privilege of members of the general public, as business invitees, to access licensed premises and to participate in licensed gaming thereon. Further, a petition to remove at any time after placement on the exclusion list envisions the possibility that a court-ordered exclusion may be satisfied at any time, even earlier than one year after Commission placement on the list.

Full text of the adoption follows:

19:42-4.5 Plenary hearing: nature of proceeding; burden of proof; issuance and service of order

(a) (No change.)

(b) The Division shall have the affirmative obligation to demonstrate by a fair preponderance of the evidence that the candidate for exclusion satisfies the criteria for exclusion established by section 71 of the Act and N.J.A.C. 19:48. In a hearing pursuant to N.J.A.C. 19:48-1.8, the excluded person shall have the affirmative obligation to show cause why he or she should be removed from the list.

(c) If, upon completion of a plenary hearing, or in the absence of a plenary hearing, upon the expiration of the time for requesting such a hearing, the Commission determines that a candidate for exclusion satisfies the criteria for exclusion established by section 71 of the Act and this chapter, the Commission shall issue a final order directing that the candidate be placed on the exclusion list until further order of the Commission. A final order directing that the candidate for exclusion shall be placed on the list, or if the candidate has been placed on the list by preliminary order of the Commission, shall remain on the list shall, within five days of its entry, be served on the candidate, the Division and all casino licensees.

(d) If, upon completion of a plenary hearing, the Commission determines that a candidate for exclusion does not satisfy the criteria for exclusion established by section 71 of the Act and this chapter, the Commission shall issue a final order denying the petition for exclusion. A final order denying a petition for exclusion shall, within five days of its entry, be served on the candidate and the Division. If the candidate has been previously placed upon the list by preliminary order of the Commission in accordance with the provisions of N.J.A.C. 19:48-1.5A, the Commission shall issue a final order directing that the excluded person be removed from the list, which order shall, within five days of its entry, be served on the excluded person, the Division and all casino licensees.

(e) (No change in text.)

19:48-1.1 Definitions

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

. . .

19:48-1.3 Criteria for exclusion

(a) The exclusion list may include any person who meets any of the following criteria:

1. A career or professional offender whose presence in a licensed casino establishment would be inimical to the interest of the State of New Jersey or of licensed gaming therein;

2. An associate of a career or professional offender whose association is such that his or her presence in a licensed casino establishment would be inimical to the interest of the State of New Jersey or of licensed gaming therein;

3. Any person who has been convicted of a criminal offense under the laws of any State, or of the United States, which is punishable by more than six months in prison, or who has been convicted of any crime or offense involving moral turpitude, and whose presence in a licensed casino establishment would be inimical to the interest of the State of New Jersey or of licensed gaming therein; or

4. Any person whose presence in a licensed casino establishment would be inimical to the interest of the State of New Jersey or licensed gaming therein, including, but not limited to:

i. Cheats;

ii. Persons whose privileges for licensure have been revoked;

iii. Persons who pose a threat to the safety of the patrons or employees of a casino licensee;

iv. Persons with a documented history of conduct involving the undue disruption of the gaming operations of casino licensees; and

v. Persons subject to an order of the Superior Court of New Jersey excluding such persons from all casino hotel facilities.

(b) For purposes of (a) above:

1. A person's presence may be considered "inimical to the interest of the State of New Jersey or of licensed gaming therein" if known attributes of such person's character and background:

i. Are incompatible with the maintenance of public confidence and trust in the credibility, integrity and stability of licensed casino gaming;

ii. Could reasonably be expected to impair the public perception of, and confidence in, the strict regulatory process created by the Act; or

iii. Would create or enhance a risk of the fact or appearance of unsuitable, unfair or illegal practices, methods or activities in the conduct of gaming or in the business or financial arrangements incidental thereto.

2. A finding of inimicality may be based upon the following:

i. The nature and notoriety of the attributes of character or background of the person;

ii. The history and nature of the involvement of the person with licensed casino gaming in New Jersey or any other jurisdiction, or with any particular casino licensee or licensees or any related company thereof;

iii. The nature and frequency of any contacts or associations of the person with any casino licensee or licensees, or with any employees or agents thereof; or

iv. Any other factor reasonably related to the maintenance of public confidence in the efficacy of the regulatory process and the integrity of gaming operations, the casino industry and its employees.

(c) (No change in text.)

19:48-1.4 Duties of the Division of Gaming Enforcement

(a) The Division shall, on its own initiative, or upon referral by the Commission, investigate any individual who would appear to be an appropriate candidate for placement on the exclusion list.

(b) (No change.)

(c) If the Division files a complaint alleging a violation of section 71d of the Act and N.J.A.C. 19:48-1.7(b)2 against any licensee, the Division shall file simultaneously a petition to exclude the person alleged in the complaint to meet the criteria for exclusion in N.J.A.C. 19:48-1.3.

(d) If, upon completion of an investigation undertaken upon referral by the Commission, the Division determines that an individual should not be placed on the exclusion list, the Division shall so state in writing to the Commission.

19:48-1.5 Procedure for entry of names

(a) The Commission may place a person on the exclusion list as follows:

1. Upon petition of the Division in accordance with the procedures set forth at N.J.A.C. 19:42-4; or

2. Upon receipt of an order of the Superior Court of New Jersey excluding such person from all casino hotel facilities. The Commission shall consider such action forthwith upon receipt of the court order, with at least 15 days notice to the Division and to such person by certified mail at his or her last known address.

19:48-1.7 Duty of casino licensee

(a) A casino licensee shall exclude or eject the following persons from its casino hotel facility:

1. Any excluded person; or

2. Any person known to the casino licensee to satisfy the criteria for exclusion set forth in section 71 of the Act and N.J.A.C. 19:48-1.3(a).

(b) If an excluded person enters, attempts to enter, or is in a casino hotel facility and is recognized by the casino licensee, the casino licensee shall immediately notify the Commission and Division of such fact.

(c) The Commission may, upon request of any casino licensee or any person who has been excluded or ejected from a casino hotel pursuant to (a)2 above, refer a matter to the Division for investigation to determine whether such person meets the criteria for exclusion provided in N.J.A.C. 19:48-1.3.

(d) (No change in text.)

19:48-1.8 Petition to remove name from exclusion list

(a) An excluded person may petition the Commission to request a hearing concerning his or her removal from the list at any time after five years from the placement by the Commission of such person on the list.

(b) (No change.)

(c) The Commission may decide the petition on the basis of the documents submitted by the parties. The Commission may summarily deny the petition or may grant the petition and direct that a hearing be held in accordance with N.J.A.C. 19:42-4.5. The Commission shall grant the petition only upon a finding that there is new evidence which is material and necessary, or that circumstances have changed since the placement of the excluded person on the list, and that there would be a reasonable likelihood that the Commission would alter its previous decision.

(d) Any excluded person who is barred from requesting a hearing concerning his or her removal from the list by (a) above may petition the Commission for early consideration at any time; provided, however, that no excluded person may, within the five-year period of exclusion, file more than one such petition. Such petition shall be verified, with supporting affidavits, and shall state with particularity any grounds upon which exclusion was based, and the facts and circumstances which warrant the relief sought. Upon receipt of such petition, the Division shall be given an opportunity to state its position in writing. The Commission may decide the petition on the basis of the documents submitted by the parties. The Commission may summarily deny the petition or may grant the petition and direct that a hearing be held in accordance with N.J.A.C. 19:42-4.5. The Commission shall grant the petition:

1. Upon a finding that there exist extraordinary facts and circumstances warranting early consideration of the excluded person's request for removal from the list; or

2. If exclusion was pursuant to N.J.A.C. 19:48-1.5(a)2, upon a finding that the excluded person has completed the period of probation or otherwise satisfied the terms of any court-ordered exclusion.

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Gaming Equipment
Casino Simulcasting

Adopted Amendments: N.J.A.C. 19:45-1.1, 1.14A; 19:46-1.20; 19:51-1.2; 19:55-1.1, 2.9, 4.3, 4.4, 4.10, 6.2, 7.1 and 8.1

Proposed: October 8, 1993 at 25 N.J.R. 4737(a).

Adopted: December 16, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: December 20, 1993 as R.1994 d.33, **with substantive changes** not requiring additional public notice or comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 5:12-63(c), 69(a), 70(g) and 99(a).

Effective Date: January 18, 1994.

Operative Date: February 22, 1994.

Expiration Dates: N.J.A.C. 19:45, August 15, 1997;
N.J.A.C. 19:46, April 15, 1998;
N.J.A.C. 19:51, April 27, 1994;
N.J.A.C. 19:55, January 19, 1998.

Summary of Public Comments and Agency Responses:

COMMENT: The Division of Gaming Enforcement (Division) supports the adoption of the proposed amendments.

RESPONSE: Accepted.

COMMENT: Resorts International Hotel, Inc. (Resorts) supports the adoption of the proposed amendments.

RESPONSE: Accepted.

Summary of Agency-Initiated Changes:

During the comment period, it became apparent to the Commission staff that two additional amendments should be made with respect to the ancillary simulcast counter provided for in N.J.A.C. 19:45-1.14(d). N.J.A.C. 19:55-4.4 requires in part that a casino simulcasting facility contain a facsimile machine and a direct dial-up telephone line. An amendment has been made to proposed N.J.A.C. 19:45-1.14(d) to permit the Commission to waive this requirement for an ancillary simulcast counter subject to the same criteria set forth for waiving the requirements of N.J.A.C. 19:45-1.14(a) and (b). Additionally, N.J.A.C. 19:55-4.4 had itself been amended to clarify that the facsimile machine and direct dial-up line must be located within the simulcast counter of the casino simulcasting facility. These agency-initiated changes merely conform the rules more specifically to existing requirements imposed by the Commission. Therefore, they will have no independent effect on the operation of casino licensees or impact upon the public and, accordingly, do not require additional public notice or comment.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

19:45-1.1 Definitions

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

...

"Simulcast handle" means the amount of currency, coin, gaming chips, slot tokens and coupons wagered by patrons on a simulcast horse race, less the value of cancelled or refunded tickets.

...

19:45-1.14A Simulcast counter

(a)-(c) (No change.)

(d) A casino simulcasting facility may contain one or more ancillary simulcast counters to house casino pari-mutuel cashiers. An ancillary simulcast counter shall comply with all of the provisions of ***N.J.A.C. 19:55-4.4 and*** (a) and (b) above; provided however, that the requirements of a separate ***facsimile machine, direct dial-up telephone line,*** RMC, simulcast vault and simulcast shift supervisor for the ancillary simulcast counter, or any of them, may be waived if, considering, among any other relevant factors, the number of pari-mutuel windows in the ancillary simulcast counter, the proximity of the ancillary simulcast counter to the simulcast counter, and the span of authority and responsibility of the supervisor, the Commission determines that any such requirement is not necessary to the maintenance of adequate supervision of the simulcast wagering operations.

19:46-1.20 Approval of gaming and simulcast wagering equipment; retention by Commission or Division; evidence of tampering

(a) The Commission shall have the discretion to review and approve all gaming and simulcast wagering equipment and other devices used in a casino, casino simulcasting facility or hub facility as to quality, design, integrity, fairness, honesty and suitability including without limitation gaming tables, layouts, roulette wheels, pokette wheels, roulette balls, drop boxes, big six wheels, sic bo shakers, sic bo electrical devices, pai gow shakers, chip holders, racks and containers, scales, counting devices, trolleys, slip dispensers, dealing shoes, dice, cards, pai gow tiles, locking devices, card reader devices, data processing equipment, pari-mutuel machines, self-service pari-mutuel machines, credit voucher machines and totalisators.

(b) (No change.)

(c) Any evidence that gaming equipment or other devices used in a casino, casino simulcasting facility or hub facility including, without limitation, gaming tables, layouts, roulette wheels, pokette wheels, roulette balls, drop boxes, big six wheels, sic bo shakers, sic bo electrical devices, pai gow shakers, gaming chips, plaques, chip holders, racks and containers, scales, counting devices, trolleys, slip dispensers, dealing shoes, locking devices, card reader devices, data processing equipment, tokens, slot machines, pari-mutuel machines, self-service pari-mutuel machines, credit voucher machines and totalisators have been tampered with or altered in any way which would affect the integrity, fairness, honesty or suitability of the gaming equipment or other device for use in a casino, casino simulcasting facility or hub facility shall be immediately reported to an agent of the Commission and the Division. A member of the casino licensee's casino security department shall be required to insure that the gaming equipment or other device and any evidence required to be reported pursuant to this subsection is maintained in a secure manner until the arrival of an agent of the Division. Rules concerning evidence of tampering with dice, cards and pai gow tiles may be found at N.J.A.C. 19:46-1.16, 19:46-1.18 and 19:46-1.19B, respectively.

19:51-1.2 License requirements

(a) (No change.)

(b) Enterprises required to be licensed in accordance with subsections 92a and b of the Act and (a) above shall include, without limitation, the following:

1. Manufacturers, suppliers, distributors, servicers and repairers of roulette wheels, roulette balls, big six wheels, gaming tables, slot machines, cards, dice, gaming chips, gaming plaques, slot tokens, dealing shoes, drop boxes, computerized gaming monitoring systems, totalisators, pari-mutuel machines, self-service pari-mutuel machines and credit voucher machines;

2.-3. (No change.)

(c)-(j) (No change.)

19:55-1.1 Definitions

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

...

"Casino pari-mutuel cashier" means a casino employee who sells pari-mutuel tickets representing simulcast wagers, sells credit vouchers for simulcast wagers, pays cash for credit vouchers, and makes simulcast payouts in a casino simulcasting facility.

...

"Credit voucher" means a ticket issued by:

1. A casino pari-mutuel cashier in exchange for cash, gaming chips, slot tokens or coupons;

2. A credit voucher machine in exchange for cash; or

3. A self-service pari-mutuel machine as a simulcast payout or as the balance returnable after a simulcast wager has been placed.

"Credit voucher machine" means a mechanical, electrical or other device connected to a totalisator which, upon the insertion of cash, automatically issues a credit voucher of an equal value.

...

19:55-2.9 Wagering limited to casino simulcasting facility

Wagering on simulcast horses within the premises of a casino licensee shall be conducted only in a casino simulcasting facility. However, pictures and sound of simulcast horse races may be shown in such other areas of the establishment as approved by the Commission.

19:55-4.3 Transmission data line

A transmission data line shall be a dedicated line. There shall be a minimum of one back-up line, which may be a dial-up line. In addition, each out-of-State sending track shall maintain a cellular phone in its totalisator room. The dedicated line requirement may be waived for good cause shown with the prior written approval of the Commission and Racing Commission.

19:55-4.4 Facsimile machines and telephone lines

A *[casino simulcasting facility]* ***simulcast counter***, hub facility and the totalisator room at a sending track shall each contain a facsimile machine and a direct dial-up telephone line, the numbers of which shall be provided to the Commission, Division and Racing Commission.

19:55-4.10 Cancellation of tickets

(a)-(b) (No change.)

(c) Except for pari-mutuel tickets which may be cancelled pursuant to (b) above, no pari-mutuel ticket purchased at a self-service pari-mutuel machine on a current race shall be cancelled.

(d)-(e) (No change.)

(f) A casino pari-mutuel cashier may cancel any pari-mutuel tickets which a patron requests, but does not pay for, provided the tickets are cancelled prior to sale of any ticket to a subsequent patron.

19:55-6.2 Simulcast wagering equipment

All manufacturers, suppliers and repairers of simulcast wagering equipment, including totalisators, pari-mutuel machines, self-service pari-mutuel machines and credit voucher machines, to casino licensees or hub facilities shall be licensed in accordance with the provisions of N.J.S.A. 5:12-92a.

19:55-7.1 Reconciliation with sending tracks

Each casino licensee which conducts casino simulcasting shall, in conformance with information provided by the hub facility, reconcile all simulcast wagers with sending tracks on at least a weekly basis unless the casino licensee and a sending track agree to a different term of payment, which shall be set forth in the agreement between the casino licensee and sending track.

19:55-8.1 Race information availability

A casino licensee which conducts casino simulcasting shall make available to patrons of its casino simulcasting facility the following information for each simulcast race: the names of entrants, their sires, dames and maternal grandsires, their wagering numbers, post positions, jockeys or drivers, assigned weight, morning line odds, owners and owners' colors or drivers' colors, trainers, sex, color, year of birth; the distance and number of the race; amount of purse; and conditions and claiming price, if any. For harness races, the performance lines for at least the last six races of each entrant shall also be available. The availability of such information, and the procedures for obtaining same, shall prominently be displayed in the casino simulcasting facility. Nothing in this chapter shall preclude a casino licensee from charging patrons a fee for providing such information.

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Complimentary Services or Items; Procedures for Complimentary Cash and Noncash Gifts
Direct Mass Marketing Complimentary Programs
Adopted Amendments: N.J.A.C. 19:45-1.9 and 1.9B

Proposed: November 1, 1993 at 25 N.J.R. 4871(b).

Adopted: December 16, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: December 20, 1993 as R.1994 d.34, **without change.**

Authority: N.J.S.A. 5:12-63c, 69a, 70j, 70l, 99 and 102.

Effective Date: January 18, 1994.

Expiration Date: August 15, 1997.

Summary of Public Comments and Agency Responses:

COMMENT: The Division of Gaming Enforcement, the Sands Hotel and Casino and the Trump Taj Mahal Casino Resort each submitted comments supporting the adoption of the proposed amendments.

RESPONSE: Accepted.

Full text of the adoption follows:

19:45-1.9 Complimentary services or items

(a)-(d) (No change.)

(e) Each casino licensee shall record, on a daily basis, the name of each person provided with complimentary services or items, the category of service or item provided, the value (as calculated in accordance with (c) above) of the services or items provided to such person, and the person authorizing the issuance of such services or items. A copy of this record shall be submitted to the Division's office located on the casino premises no later than two days subsequent to its preparation. Excepted from this requirement are the individual names of persons authorizing or receiving:

1. (No change.)

2. Any complimentary service or item, including a cash or noncash gift, which is issued pursuant to:

i. (No change.)

ii. A complimentary program for invited guests regulated by (g) below;

iii. A direct mass marketing complimentary program regulated by (h) below; or

iv. (No change in text.)

(f)-(g) (No change.)

(h) Any complimentary service or item, including a complimentary cash or noncash gift, which is issued to a patron as part of a direct mass marketing complimentary program shall be subject to the requirements of N.J.A.C. 19:45-1.46 and this subsection and shall not be included on the daily complimentary report required by (e) above or subject to the annual limitation on cash complimentaries established by N.J.A.C. 19:45-1.9B(g) if:

1. The program is submitted to and approved by the Commission in accordance with the requirements of N.J.A.C. 19:45-1.46 as if the program were a complimentary distribution program; provided, however, that detailed procedures controlling a direct mass marketing complimentary program which is subject to the provisions of N.J.A.C. 19:45-1.46(b) and which includes complimentary cash, slot tokens or simulcast wagering shall not have to be submitted to the Commission 15 days prior to implementation of the program, but may instead be prepared prior to implementation of the program and maintained as an accounting record by the casino licensee if:

i. The casino licensee has previously submitted and the Commission has previously approved generic internal control procedures governing direct mass marketing complimentary programs; and

ii. No material element of the direct mass marketing complimentary program varies from the generic internal control procedures previously approved by the Commission;

2. The complimentary services or items offered pursuant to the program do not exceed $100.00 per person per day and are offered to at least 500 persons within 30 days from the implementation of the program;

3. A record, which shall be available to the Division upon request, is maintained identifying:

i. The date the program was implemented;

ii. The value and type of the complimentary services or items offered pursuant to the program;

iii. The number of persons to whom the complimentary services or items were offered and the date that the offer was made;

iv. The source of the names of the persons to whom the complimentary services or items were offered; and

v. If the casino licensee has possession of the data, the names and addresses of the persons to whom cash complimentaries were offered, which data shall be maintained in accordance with the requirements of N.J.A.C. 19:45-1.8(c)6.

19:45-1.9B Procedures for complimentary cash and noncash gifts

(a) No casino licensee shall offer or provide, either directly or indirectly, any complimentary cash or noncash gift to any person or his or her guests except in accordance with the provisions of N.J.S.A. 5:12-102m and this section. For the purposes of this section, "complimentary cash or noncash gift" does not refer to any complimentary service or item which is provided pursuant to N.J.S.A. 5:12-102m(1) through (3), N.J.A.C. 19:45-1.9(f), 19:45-1.9(h) or 19:45-1.46. Complimentary cash gifts shall include, without limitation:

1.-5. (No change.)

(b)-(g) (No change.)

(h) Notwithstanding the provisions of (g) above, complimentary cash gifts which are provided to persons pursuant to complimentary incentive programs regulated by N.J.A.C. 19:45-1.9(f), complimentary programs for invited guests regulated by N.J.A.C. 19:45-1.9(g), direct mass marketing complimentary programs regulated by N.J.A.C. 19:45-1.9(h) or complimentary distribution programs regulated by N.J.A.C. 19:45-1.46 shall be governed by any limitations contained in those respective rules and shall not be subject to the annual limits specified in (g) above.

(a)

CASINO CONTROL COMMISSION

Notice of Administrative Correction
Gaming Equipment
Dealing Shoes
N.J.A.C. 19:46-1.19

Take notice that the Casino Control Commission has discovered an error in the current text of N.J.A.C. 19:46-1.19(b). The last phrase of the second sentence of the subsection, "during non-gaming hours," was deleted and replaced by "when the table is not open for gaming activity" effective March 2, 1992 (see 23 N.J.R. 3243(a) and 24 N.J.R. 858(c)). However, a subsequent adopted amendment to this subsection inadvertently reintroduced the deleted text into the subsection as contained in the Administrative Code (see 24 N.J.R. 3742(a)). This notice, published in accordance with N.J.A.C. 1:30-2.7, returns the subsection to its intended form.

Full text of the corrected rule follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

19:46-1.19 Dealing shoes

(a) (No change.)

(b) Cards used to game at blackjack, pai gow poker, minibaccarat, and red dog shall be dealt from a dealing shoe which shall be secured to the gaming table when the table is open for gaming activity and secured in a locked compartment when the table is not open for gaming activity. Cards used to game at baccarat shall be dealt from a dealing shoe which shall be secured in a locked compartment [during non-gaming hours] **when the table is not open for gaming activity**. Notwithstanding the foregoing, cards used to game at pai gow poker may be dealt from the dealer's hand in accordance with N.J.A.C. 19:47-11.8A.

(c)-(g) (No change.)

(b)

CASINO CONTROL COMMISSION

Casino Hotel Alcoholic Beverage Control
Readoption: N.J.A.C. 19:50

Proposed: October 18, 1993 at 25 N.J.R. 4742(a).

Adopted: December 3, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: December 15, 1993 as R.1994 d.29, **without change.**

Authority: N.J.S.A. 5:12-70q and 103.

Effective Date: December 15, 1993.

Expiration Date: December 15, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption may be found in the New Jersey Administrative Code at N.J.A.C. 19:50.

PUBLIC NOTICES

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

DIVISION OF SOLID WASTE

Notice of Action on Rule Petition Economic Regulation of the Solid Waste Industry

Petitioner: Sandra T. Ayres

Take notice that on September 17, 1993 the Department of Environmental Protection and Energy (Department) received a portion for the identification, clarification and reproposal of the regulations affecting the economic regulation of the solid waste industry now codified in Title 14 of the New Jersey Administrative Code (N.J.A.C.). (see 25 N.J.R. 4795(d)).

Petitioner Sandra T. Ayres, is an attorney with Schwartz, Tobia & Stanziale in Montclair, New Jersey. Petitioner represents solid waste companies subject to Department economic regulation. Petitioner asserts that since the transfer of regulatory authority from the former Board of Public Utilities to the Department it is unclear which of the rules previously adopted by the Board are being implemented by the Department.

The petitioner requests that the Department review Title 14, identify the rules relevant to the economic regulation of the solid waste industry, modify these rules as necessary and recodify these rules in Title 7, of the N.J.A.C. Petitioner also requests that the Department repropose any rules which it may rely upon that have been deleted by the new Board of Regulatory Commissioners.

The Department is currently engaged in revising, updating and clarifying those rules in Title 14 which impact on the economic regulation of the solid waste industry. The Department intends to repropose those rules in Title 7. The Department expects to publish proposed regulations in the New Jersey Register by May 1, 1994.

For additional information contact Beth Stzuk, Economic Regulation, Division of Solid Waste Management at 609-530-8230.

As required under N.J.A.C. 1:30-3.6, the Department has mailed the Notice of Action on the petition to the petitioner.

(b)

DIVISION OF SOLID WASTE MANAGEMENT

Solid Waste Management State Plan Update: 1993-2002

Notice of Adoption of Section 1: Municipal and Industrial Solid Waste

Take notice that, pursuant to the provisions of the New Jersey Solid Waste Management Act (N.J.S.A. 13:1E-1 et seq. and the Federal Resource Conservation and Recovery Act (42 U.S.C. 6901 et seq.), the Department of Environmental Protection and Energy (Department) has adopted the Solid Waste Management State Plan Update: 1993-2002, Section 1: Municipal and Industrial Solid Waste (State Plan Update). Public notice of the proposed State Plan Update was published in the February 16, 1993 New Jersey Register at 25 N.J.R. 721(d). Three regional public hearings were held on March 16, 17 and 18, 1993. The formal public comment period ended on March 31, 1993. However, due to numerous requests to extend the comment period to provide additional time to submit comments, the Department continued to accept comments until April 21, 1993.

The Department has prepared a Responsiveness Summary, which addresses comments presented at the public hearing and submitted in writing during the public comment period, and an Addendum, which contains all changes made in the final State Plan Update on adoption. The Department is printing the final State Plan Update incorporating all changes made on adoption and contained within the Addendum. The Department will mail the Responsiveness Summary, the Addendum, and the final State Plan Update to all those who participated in the public review and comment process, to all those on standard mailing lists maintained by the Department, to every municipality, to all county solid waste management offices, and to all libraries in the State's central repository system.

Copies of the Responsiveness Summary, Addendum, and final State Plan Update may be obtained by calling or writing to:

Bureau of Source Reduction, Market Development,
and County Planning
Division of Solid Waste Management
840 Bear Tavern Road, CN 414
Trenton, NJ 08625
(609) 530-8203

(c)

DIVISION OF PARKS AND FORESTRY HISTORIC PRESERVATION OFFICE

Notice of Availability of Grant Funds Fiscal Year 1994 Historic Preservation Fund Matching Grants

Take notice that the Historic Preservation Office (HPO) announces the following availability of funds.

A. Name of the grant program that has funds available: Fiscal Year 1994 Historic Preservation Fund.

B. Purpose for which the grant program funds shall be used: The Historic Preservation Office has funds available for the identification, evaluation, registration, and protection of historic and prehistoric resources in New Jersey. A limited amount of historic preservation survey and planning funds are available to State agencies, county and municipal governments, academic institution, private not-for-profit organizations, and individuals. Funding is available on a 60 percent Federal, 40 percent local matching share basis. Allowable activities, as outlined in **The National Register Programs Guidelines NPS-49,** include:

1. CLG historic preservation municipal master plan element. The project **must** at minimum comprise the following:

a. Preparation of a historic preservation plan element of the municipal Master Plan in accordance with the requirements of the New Jersey Municipal Land Use Law, the New Jersey State enabling legislation for local historic preservation ordinances. The Municipal Land Use Law (N.J.S.A. 40:55D-28b.(10)) requires that the historic preservation plan element of a Master Plan indicate the "location and significance of historic sites and districts," identify the "standards used to assess worthiness for historic site or district identification," and analyze the "impact of each component and element of the Master Plan on the impact of preservation of historic sites and districts;"

b. Analysis of the compatibility of existing and proposed municipal historic preservation overlay zoning with the goals and objectives of the New Jersey State Development and Redevelopment Plan (State Plan) and the accommodation of future development in identified or planned "Centers" within the municipality;

c. Identification of the civic and economic benefits of the local historic preservation program as well as the contribution of design review guidelines to the protection and preservation of historically and architecturally significant properties; and

d. Provide, to the greatest extent possible, the public with the opportunity to participate in the development and review of the historic preservation plan element.

2. CLG municipal surveys and non-CLG county-wide surveys. Historic resource surveys to identify significant sites, buildings, structures, streetscapes and districts within a given geographic area. All historic resource data must be recorded on HPO approved survey forms which are incorporated into the New Jersey Historic Sites Inventory. **For county-wide surveys covering a large geographic area the HPO recommends a two year phased approach to completing the project.** The HPO recommends that all new survey applications include an archaeological component. **All historic resource surveys must be prepared in accordance with the Secretary of the Interior's Standards for Identification and Evaluation, National Register Bulletin 24, and submitted on HPO approved survey forms.**

3. CLG historic preservation planning and education projects. This category includes the development of site specific, historic district or municipal preservation plans, design guidelines, preparation of National Register of Historic Places nominations, public education programs (National Register Program related publications and videos) and sponsorship of local government preservation planning staff who undertake historic preservation planning activities consistent with HPO standards and requirements. **All planning projects must conform to the appropriate Secretary of the Interior's Standards and Guidelines (for example, Planning, Identification, Evaluation, Registration, Historical Documentation).**

4. CLG historic structure report. Site specific historic structure report (HSR) for architectural and historic resources listed on the National Register of Historic Places. A HSR is the report required prior to the development of a historic resource when the rehabilitation and/or restoration work involves fabricating significant missing architectural or landscape features, recapturing the appearance of a property at one particular period of its history or removing non-contributing additions. **All reports must be prepared in accordance with the applicable Secretary of the Interior's Standards for Historic Preservation Projects and the HPO Historic Structures Report Guidelines.**

5. CLG plans and specifications (construction documents). Plans and specifications for sites or resources listed on the National Register of Historic Places. These documents include detailed working drawings and technical specifications necessary to guide the construction, determine the scope of work, and provide the firm basis for competitive bidding and contractual obligations. **All documents must be prepared in accordance with the applicable Secretary of the Interior's Standards for Historic Preservation Projects.**

6. CLG archaeological resource protection, stabilization or preservation plans. Site specific archaeological resource protection, stabilization or preservation plans. The plans include the research or investigation necessary to document proposed protection, stabilization or preservation of archaeological resources or the recovery of archaeological data. **All plans must be prepared in accordance with the applicable Secretary of the Interior's Standards for Historic Preservation Projects and Archaeological Investigation.**

C. Amount of money in the grant program: Approximately $62,000 of Federal matching funds is available for projects undertaken by Certified Local Governments. Approximately $25,000 of Federal Matching funds is available for projects undertaken by State agencies, county and municipal governments, academic institutions, private and not-for-profit organizations, and individuals.

D. Groups or entities which may apply for the grant program: State agencies, county and municipal governments, academic institutions, private and not-for-profit organizations, and individuals are eligible to apply for grants under the program. Only municipalities participating in the Certified Local Government program may apply for grants under the Certified Local Government grants program.

E. Qualifications needed by an applicant to be considered for the grant program: The HPO uses a competitive selection process and awards grants to projects which best meet the criteria described in the application packet. The criteria for evaluating grant applications is as follows:

Criteria for Evaluating Grant Applications

1. Project demonstrates consistency with the goals and objectives of the New Jersey State Development/Redevelopment Plan and where appropriate the Municipal Land Use Law. **(points 0-10)**

2. Project's advancement of the goals and objectives of the New Jersey Historic Preservation Plan (Appendix C). Applicants must cite specific points from the Historic Preservation Plan. **(points 0-5)**

3. The degree to which the project is actively linked to environmental protection, natural resource or open space preservation, and/or public education activities, goals and objectives. The degree to which the project is an active component of the land use, environmental or community development and redevelopment planning process or Main Street New Jersey Program. **(points 0-5)**

4. The Applicant has addressed all items and related components of the grant application in a clear, concise and detailed manner. The project methodology and expectations are adequately described to enable the HPO to fully understand the need to provide grant assistance. **(points 0-25)**

5. The Applicant has adequately described all products, services and expected deliverables in a clear, concise and detailed manner. All products and deliverables to be turned over to the HPO and those to be retained by the applicant are disclosed. **(points 0-25)**

6. Project's degree of outreach as demonstrated by applicant's ability to involve and impact new audiences and special constituencies. **(points 0-5)**

7. The degree to which the project will involve minorities, handicapped and/or under-represented communities and interests. **(points 0-3)**

8. The applicant demonstrates that the results of the proposed project will serve as a model for other communities within the state. **(points 0-5)**

9. Inclusion of a relevant archaeological component within a cultural resource survey. **(points 0 or 1)**

10. Degree to which the project will identify or protect historic resources threatened by development pressures. Development pressures may result from one (1) or more of the following:

- New economic or development activity (residential, commercial, industrial)
- Population growth
- Abandonment or neglect
- Inappropriate or insensitive alterations
- Publicly funded encroachments such as transportation or public works projects **(points 0-5)**

11. Applicant demonstrates that **qualified** personnel will be allocated to administer the project. Contract or in-kind personnel must include:

- Project Coordinator
- Chief Financial Officer and should include:
- Clerical staff **(points 0-5)**

12. Applicant provides documentation that within the past two years it has undergone a successful audit of its finance or accounting system. **(points 0 or 5)**

13. Applicant provides evidence that the project budget is appropriate to the scope of the project. **(points 0-10)**

14. Applicant demonstrates that the project can be completed within the proposed time-frame. Appropriate bench marks are established in the schedule to allow the Applicant and HPO to monitor product and budgetary performance. **(points 0-5)**

15. The Applicant has a demonstrated ability to properly manage the grant, for example, acceptable performance on prior subgrant or other historic preservation projects:

- Fiscal documentation met program requirements.
- Completed the project on time and within budget.
- Project did not result in NPS recapture of funds.
- Consultant selection and contracting were accomplished in a timely manner with minimum HPO direction.
- Written requests to extend project deadlines were provided to HPO in compliance with the grant agreement.
- Interim reporting deadlines met consistently.
- Interim product deadlines met consistently.
- Final reporting deadlines were met.
- Final product deadlines were met. **(possibly total points –8 or +18 or 2 points ± each)**

HPO Funding Priorities for FY 1994

District funding priorities have been established for the Certified Local Government (CLG) Program and the Survey and Planning Program.

Certified Local Government (CLG) Program Priorities:

- Historic Preservation Municipal Master Plan Element **(15 points)**
- Historic preservation education projects promoting the benefits and/or informing the public of historic preservation plans, ordinances, policies and procedures **(points 15)**
- Municipal historic resources survey with a preservation strategy. **(points 5)**
- New Jersey and National Register historic district nomination(s). **(points 5)**

Survey and Planning Program Priority:

- Phased two to three year commitment to fund a county-wide historic resource survey targeted specifically for **Cape May, Camden, Cumberland, Essex, Hudson, Passaic, Salem or Sussex Counties.**

F. Procedure for eligible entities to apply for grant funds: Application forms, guidelines, and information on applicant and project eligibility are available from:

Historic Preservation Office
CN 404
Trenton, New Jersey 08625
(609) 292-2028

G. Address of office receiving application:
Historic Preservation Office
CN 404
Trenton, New Jersey 08625

H. Deadline by which applications must be submitted to the office: The deadline for submission of Fiscal Year 1994 applications is 5:00 P.M., March 31, 1994.

I. Date by which applicants shall be notified whether they will receive funds under the grant program: The Historic Preservation Office will notify applicants of approval or disapproval by June 30, 1994.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Sussex County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Sussex County Water Quality Management (WQM) Plan. The amendment proposal has been submitted by the Sussex County Department of Planning and Development. This amendment would adopt a Wastewater Management Plan (WMP) for Andover Township. The WMP proposes a new sewage treatment plant (STP) discharging to ground water to serve a proposed senior citizens complex (Life Care Mews). The projected wastewater flow to this STP is 60,000 gallons per day. The WMP also identifies the existing STPs within the Township, their service areas, and the projected ground water disposal service areas (with specific gallons per acre per day limitations based on watershed and geologic formation).

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Sussex County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the Sussex County Department of Planning and Development, Division of Environmental Resource Planning, County Administration Building, P.O. Box 709, Newton, New Jersey 07860; and the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling either the Office of Land and Water Planning at (609) 633-1179 or the Sussex County Department of Planning and Development at (201) 579-0500.

The Sussex County Board of Chosen Freeholders will hold a **public meeting** on the proposed Sussex County WQM Plan amendment at which time all interested persons may appear and shall be given an opportunity to be heard. The public meeting will be held on Wednesday, February 23, 1994 at 6:00 P.M. in the Freeholder meeting room, County Administration Building, Plotts Road, Newton, New Jersey.

Interested persons may submit written comments on the amendment to Mr. George Krauss, Sussex County Department of Planning and Development, at the address cited above, with a copy sent to Dr. Daniel J. Van Abs, Office of Land and Water Planning, at the NJDEPE address cited above. All comments must be submitted within 15 days following the public meeting. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by the Sussex County Board of Chosen Freeholders with respect to the amendment request. In addition, if the amendment is adopted by Sussex County, the NJDEPE must review the amendment prior to final adoption. The comments received in reply to this notice will also be considered by the NJDEPE during its review. Sussex County and the NJDEPE thereafter may approve and adopt this amendment without further notice.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Northeast Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Northeast Water Quality Management (WQM) Plan. This amendment proposal was submitted on behalf of the Southeast Morris County Municipal Utilities Authority (SMCMUA). The amendment would update both the Florham Park Sewerage Authority (FPSA) and Hanover Township Sewerage Authority Wastewater Management Plans in regard to the SMCMUA Black Brook Water Treatment Plant in Hanover Township, Morris County. The amenment would allow the filter backwash water from the Water Treatment Plant, approximately 8,000 gallons per day, which is currently discharging directly to Black Brook, to be treated by the FPSA sewage treatment plant (STP) instead. The FPSA STP discharges to the Passaic River.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and develop-

ment in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Northeast WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. David M. Gaddis, Camp Dresser & McKee, Raritan Plaza 1, Raritan Center, Edison, New Jersey 08818. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Northeast Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Northeast Water Quality Management (WQM) Plan. This amendment proposal was submitted by New Jersey Transit. The amendment proposes treatment of the industrial wastewater from a proposed New Jersey Transit bus maintenance facility in Wayne Township, Passaic County by the Passaic Valley Sewerage Commissioners sewage treatment plant (STP) in Newark City, Essex County (discharge to the Upper New York Bay). The projected industrial flow is approximately 15,000 gallons per day. Sanitary wastewater from the proposed bus maintenance facility will be treated at Wayne Township's Mountain View STP which discharges to Singac Brook.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Northeast WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. Nicholas J. Valente, New Jersey Transit, Environmental Services Unit, One Penn Plaza East, Newark, New Jersey 07105-2246. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Northeast Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Northeast Water Quality Management (WQM) Plan. This amendment proposal was submitted on behalf Parsippany-Troy Hills Township. The amendment would adopt a Wastewater Management Plan (WMP) for Parsippany-Troy Hills Township. The WMP delineates the existing and proposed sewer service areas to the Parsippany-Troy Hills sewage treatment plant (STP) which discharges to the Whippany River. The proposed sewer service areas include portions of Parsippany-Troy Hills, Montville, East Hanover and Denville Townships and portions of Mountain Lakes Borough. The WMP also delineates the portions of Parsip-

pany-Troy Hills Township served by the Morris-Butterworth STP, the Rockaway Valley Regional Sewerage Authority STP, the Hanover Township Sewerage Authority STP, and the Greystone Hospital STP.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Northeast WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. George Rynkiewicz, Municipal Building, 1001 Parsippany Blvd., Parsippany, New Jersey 07054. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Northeast Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Northeast Water Quality Management (WQM) Plan. This amendment proposal was submitted by the Jefferson Township Board of Education. The amendment would update the Jefferson Township Wastewater Management Plan to include Cozy Lake School in the on-site ground water disposal facility service area for facilities with a design capacity of less than 20,000 gallons per day (gpd). The on-site ground water disposal facility serving the Cozy Lake School is proposed to be expanded to serve an expanded student population of 285 with a corresponding wastewater flow of 4,275 gpd.

This notice is being given to inform the public that a plan amendment has been proposed for the Northeast WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. John Elam, Elam and Popoff, 21-00 Route 208, P.O. Box 1038, Fairlawn, New Jersey 07410. All comments must be submitted within 10 working days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Upper Raritan Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Upper Raritan Water Quality Management (WQM) Plan. This amendment, submitted on behalf of Stanton Properties, would revise the Readington-Lebanon Wastewater Management Plan. The proposed amendment would allow Stanton Properties to expand their sewer service area to include Block 51, Lots 10 and 11, and Block 45, Lot 26.01 subdivided into 7 lots, and a portion of Lot 26. Stanton Properties is identified in the Readington-Lebanon Wastewater Management Plan as a ground water disposal facility. The proposed amendment will increase the projected population within Stanton Properties to 866 persons and a wastewater flow to 0.0721 million gallons per day.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact location and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plant); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Upper Raritan WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, Office of Land and Water Planning, at the NJDEPE address cited above with a copy sent to Robert J. Clerico, Van Cleef Engineering Associates, 1128 Route 31, Lebanon, New Jersey 08833. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Monnmouth County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Monmouth County Water Quality Management (WQM) Plan. This amendment proposal was submitted by the Western Monmouth Utilities Authority (WMUA). The amendment would modify the Bayshore Regional Sewerage Authority (BRSA) and the WMUA Wastewater Management Plans. This amendment proposes to expand the existing BRSA sewer service area to include one single family home on 8.81 acres located at Block 146, Lot 22 in Marlboro Township. The anticipated wastewater flow from the site is 400 gallons per day and is proposed to be treated at the WMUA Pine Brook Sewage Treatment Plant, thus this property will be located in a "special" BRSA service area.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Monmouth County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. Kevin Toolan, P.E., Western Monmouth Utilities Authority Engineer, T & M Associates, Eleven Tindall Rd., Middletown, New Jersey 07748. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Monmouth County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Monmouth County Water Quality Management (WQM) Plan. This amendment proposal was submitted by Richard A. Kosenski, P.E., on behalf of the Township of Middletown Sewerage Authority. The amendment would modify the Township of Middletown Sewerage Authority (TOMSA) Wastewater Management Plan by expanding the sewer service area of the TOMSA Sewage Treatment Plant to include a 48.69 acre parcel located at Block 486, Lots 17 through 22, just south of Kings Highway East in Middletown Township. The parcel includes a small portion of the Chapel Hill Historical District on part of Lots 21 and 22 which presently receives sewer service. The remaining area of the amendment would service 30 proposed single family homes, each with individual grinder pump stations. The maximum amount of projected wastewater flow from the project site is 12,000 gallons per day.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Monmouth County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. Richard Kosenski, Township of Middletown Sewerage Authority, Box 205, Center Avenue, Belford, New Jersey 07718. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Mercer County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Mercer County Water Quality Management (WQM) Plan. The amendment proposal was submitted on behalf of Toll Brothers Incorporated. This proposal would amend the Washington Township Wastewater Management Plan (WMP) to include the "Washington Greene" housing project site located at Block 25, Lots 9, 10, 11, 15, 19, 20, 21, 22, 33, 34, 35, 36, 41, and portions of Lots 2 and 43 (also of Block 25) south of Munn's Run to the sewer service area of the Hamilton Township Water Pollution Control Facility. The ultimate buildout of the "Washington Greene" housing project site would result in 93 single family homes discharging a wastewater flow of 28,000 gallons per day. This proposed amendment would also add Block 25, Lots 18.01, 18.02, 18.03, 23, 24, 40, 44, 45, and 49 to the sewer service area of the Hamilton Township Water Pollution Control Facility. These lots include 9 private owned homes currently served by the Hamilton Township Water Pollution Control Facility but not identified within the Washington Township WMP.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Mercer County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the Mercer County Planning Division, McDade Administration Building, Room 412, 640 South Broad Street, P.O. Box 8068, Trenton, New Jersey 08650; and the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling either the Mercer County Planning Division at (609) 989-6545 or the Office of Land and Water Planning at (609) 633-1179.

The Mercer County Planning Board will hold a **public hearing** on the proposed WQM Plan amendment. The public hearing will be Wednesday, March 9, 1994 at 8:30 A.M. in Room 211 of the McDade Administration Bulding. **Interested persons** may submit written comments on the proposed amendment to the Secretary, Mercer County Planning Board at the address cited above; and to Dr. Daniel J. Van Abs, Office of Land and Water Planning, at the NJDEPE address cited above. All comments must be submitted within 15 days following the public meeting. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by the County Planning Board and the County Executive with respect to the amendment request. In addition, if the amendment is adopted by Mercer County, the NJDEPE must review the amendment prior to final adoption. The comments received in reply to this notice and to the public hearing will also be considered by the NJDEPE during its review. Mercer County and the NJDEPE thereafter may approve and adopt this amendment without further notice.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Mercer County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Mercer County Water Quality Management (WQM) Plan. This amendment proposal was submitted on behalf of the Township of Princeton and the Borough of Princeton. The proposed amendment changes the Stony Brook Regional Sewerage Authority (S.B.R.S.A.) sewer service area in two areas of Princeton Township: (1) The flows in the area of the Township presently served by the Montgomery Stage II sewage treatment plant will be re-directed to the S.B.R.S.A. sewage treatment plant; and, (2) Residential R-HF-W zoned areas in the southern portion of the Township will be removed from the sewer service area while adjacent areas will be added to the sewer service area. Additionally, the proposed amendment updates the Princeton Township/ Princeton Borough Wastewater Management Plan regarding abandonment of the Pretty Brook Sewage Treatment Plant.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations,

interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Mercer County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the Mercer County Planning Division, McDade Administration Building, Room 412, 640 South Broad Street, P.O. Box 8068, Trenton, New Jersey 08650; and the NJDEPE, Office of Land and Water Planning, 401 East State Street, CN-423, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling either the Mercer County Planning Division at (609) 989-6545 or the Office of Land and Water Planning at (609) 633-1179.

The Mercer County Planning Board will hold a **public hearing** on the proposed WQM Plan amendment. The public meeting will be held on Wednesday, March 9, 1994 at 8:30 A.M., in Room 211 of the McDade Administration Building.

Interested persons may submit written comments on the proposed amendment to the Secretary, Mercer County Planning Board at the address cited above; and to Dr. Daniel J. Van Abs, Office of Land and Water Planning, at the NJDEPE address cited above. All comments must be submitted within 15 days following the public hearing. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by the County Planning Board and the County Executive with respect to this amendment request. In addition, if the amendment is adopted by Mercer County, the NJDEPE must review the amendment prior to final adoption. The comments received in reply to this notice will also be considered by the NJDEPE during its review. Mercer County and the NJDEPE thereafter may approve and adopt this amendment without further notice.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Mercer County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Mercer County Water Quality Management (WQM) Plan. This proposed amendment, submitted on behalf of the East Windsor Township Municipal Utilities Authority (EWTMUA), would expand the sewer service area of the EWTMUA to include the following parcels: Block 46, Lots 1-3, Block 47, Lots 13-29, and Block 50, Lots 1-5, a portion of 6, 6.01, 7, 7.01, 8, 14, 15, 17, 18, and 18.01. This amendment is a result of East Windsor Township rezoning various parcels in December 1992, to either R-1/Residential Low Density or HC/Highway Commercial.

This proposed amendment would also amend the Washington Township WMP wherein Block 14, Lot 56, located on Hankins Road in Washington Township and experiencing septic failure, would be added to the EWTMUA sewer service area. Currently, this property is identified in the "Future Service Area of the Hamilton Township Treatment Plan within Washington Township".

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Mercer County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the Mercer County Planning Division, McDade Administration Building, Room 412, 640 South Broad Street, P.O. Box 8068, Trenton, New Jersey 08650; and the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling either the Mercer County Planning Division at (609) 989-6545 or the Office of Land and Water Planning at (609) 633-1179.

The Mercer County Planning Board will hold a **public hearing** on the proposed WQM Plan amendment. The public hearing will be Wednesday, March 9, 1994 at 8:30 A.M. in Room 211 of the McDade Administration Bulding. **Interested persons** may submit written comments on the proposed amendment to the Secretary, Mercer County Planning Board at the address cited above; and to Dr. Daniel J. Van Abs, Office of Land and Water Planning, at the NJDEPE address cited above. All comments must be submitted within 15 days following the public meeting. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by the County Planning Board and the County Executive with respect to the amendment request. In addition, if the amendment is adopted by Mercer County, the NJDEPE must review the amendment prior to final adoption. The comments received in reply to this notice and to the public hearing will also be considered by the NJDEPE during its review. Mercer County and the NJDEPE thereafter may approve and adopt this amendment without further notice.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Tri-County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process

in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Tri-County Water Quality Management (WQM) Plan. This proposed amendment, submitted on behalf of K. Hovnanian Companies of the Delaware Valley, Inc. The amendment would modify the Mansfield Township Wastewater Management Plan by identifying a new 425,000 gallons per day (GPD) wastewater collection, treatment and discharge to ground water disposal system to serve the proposed Mansfield Farms residential development, affordable housing units, associated recreational and commercial facilities, and an allocation for future school use. This development comprises two tracts on the northeast side of Route 68 and a tract on the southwest side of Route 68 and to the south of the Northern Burlington County Regional Jr./ Sr. High School property. A total of 1154 townhouse units are proposed (97-two bedroom units, 303-three bedroom units and 754-four bedroom units) with a projected population of 5,273. In addition, 20,000 square feet of commercial/retail space is proposed. An allotment of 25,000 gpd will be reserved for the Township for future school(s).

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Tri-County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons should submit written comments on the proposed amendment to the Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to McClellan G. Blair, Ph.D., Aqueonics, Inc., One Robar Circle, New Kensington, PA 15068. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by the County Planning Board and the County Executive with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public heraing on the amendment (or extend the public comment period in this notice up to 30 additional days). These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of the date of this notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Tri-County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comments on a proposed amendment to the Tri-County Water Quality Management (WQM) Plan. This amendment proposal was submitted on behalf of Oscar Olt. The amendment would modify the Medford Township Wastewater Management Plan (WMP) by expanding the sewer service area of the Medford Lakes Borough Sewage Treatment Plant (STP) to include two proposed residential lots (Blocks 4807, Lots 2.02 and 2.03) in Medford Township. An existing home on Block 4807, Lot 2 (to be lot 2.01 after subdivision) is already served by the Medford Lakes Borough STP. The estimated wastewater flow from the two lots is 600 gpd. The amendment will also update the Medford Township WMP by correctly identifying all three lots as being within Medford Township, not Medford Lakes Borough, and will identify the existing service connection to the house on Lot. 2.01. The project site lies within the Pinelands and can be considered to be consistent with the requirements of the Pinelands Comprehensive Management Plan.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Tri-County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling either the Office of Land and Water Planning at (609) 633-1179.

Interested persons should submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. George R. Everland & Associates, 107 Medford-Mount Holly Road, Medford, New Jersey 08055. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Tri-County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Tri-County Water Quality Management (WQM) Plan. This amendment proposal was submitted on behalf of Tabernacle Township. The amendment would adopt the Tabernacle Township Wastewater Management Plan (WMP). This WMP was submitted to NJDEPE in response to the deadline, for WMP submittal imposed for Wastewater Management Planning agencies identified in the Statewide Water Quality Management Planning Rules (N.J.A.C. 7:15). Tabernacle Township is located entirely within the Pinelands and no new wastewater disposal facilities are proposed. The WMP identifies three existing ground water discharges for three Township Schools. The WMP also identifies areas where on-site ground water disposal systems less than 20,000 gallons per day (GPD) and individual on-site ground water disposal systems less than 2,000 gpd would be appropriate.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Tri-County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons should submit written comments on the proposed amendment to the Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. Thomas J. Gatti, Alaimo Associates, 200 High Street, Mt. Holly, NJ 08060. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public heraing on the amendment (or extend the public comment period in this notice up to 30 additional days). These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of the date of this notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Tri-County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Tri-County Water Quality Management (WQM) Plan. This amendment proposal was submitted on behalf of Edward and Corinne Eget, owners of Olde York Country Club. The amendment would identify a 10,500 gallons per day wastewater collection, treatment and discharge to ground water disposal system to serve the proposed Olde York Country Club facilities to be located at Block 701, Lot 2A in Chesterfield Township and Block 1, Lot 5A in Mansfield Township, Burlington County. The country club will include a club house and banquet hall with a proposed limited membership of 300 persons. No permanent housing units are proposed for the project site. This amendment proposal will also modify the Mansfield Township Wastewater Management Plan by identifying Block 1, Lot 5A within Mansfield Township as sewer service area of the proposed new wastewater disposal system.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Tri-County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Mr. Philip G. Sudol, Applied Environmental Systems, Inc., 2 Clerico Lane, P.O. Box 1079, Belle Mead, N.J. 08502-1079. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Lower Delaware Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Manage-

ment Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Lower Delaware Water Quality Management (WQM) Plan. This amendment was submitted on behalf of Fairton Trailer Park. The amendment acknowledges the existing Fairton Trailer Park discharge(s) to ground water at a planning flow rate of 46,900 gallons per day (gpd) from 130 existing units and four additional planned and approved units, previously not identified in the Lower Delware WQM Plan. This amendment proposes an expansion to the existing Fairton Trailer Park discharge(s) to ground water to serve an additional nine units with a projected planning flow rate of 3,140 gpd. Fairton Trailer Park is located at Clark's Pond Road and Ramah Road, being Block 35, Lot 2 and Block 36, Lot 64, a total of approximately 16.75 acres in Fairfield Township, Cumberland County. A total of 143 units with a projected wastewater planning flow of 50,050 gpd is proposed.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Lower Delaware WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons should submit written comments on the proposed amendment to the Dr. Daniel J. Van Abs, Office of Land and Water Planning, at the NJDEPE address cited above with a copy sent to Margaret B. Carmeli, Esq., Giordano, Halleran & Ciesla, 125 Half Mile Road, P.O. Box 190, Middletown, New Jersey 07748. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that NJDEPE hold a nonadversarial public heraing on the amendment (or extend the public comment period in this notice up to 30 additional days). These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of the date of this notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Cape May County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Cape May County Water Quality Management (WQM) Plan. This amendment proposal has been submitted on behalf of McIntyre Enterprises, Inc. The amendment proposes to expand the sewer service area to the Ocean City Regional sewage treatment plant, which discharges to the Atlantic Ocean, to include areas of existing commercial development along Roosevelt Boulevard in Upper Township. Included in the proposed sewer service area are Yesterday's Restaurant and Liquor Store, Obadiah's Restaurant, Obadiah's Fish Market, Boulevard Liquors, All Seasons Marina and Mentzer Marine, Inc. The existing ground water disposal systems serving the existing facilities would be abandoned.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Cape May County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the Cape May County Department of Health, DN 601, Central Mail Room, 4 Moore Road, Cape May Court House, New Jersey 08210, and the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling either the Cape May Department of Health at (609) 465-1187 or the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to Mr. Grover Webber, Cape May County Department of Health at the address cited above. A copy of the comments should be sent to Dr. Daniel J. Van Abs of the Office of Land and Water Planning, at the NJDEPE address cited above. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that the Cape May Planning Board hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Mr. Webber at the Cape May County Department of Health address cited above with a copy sent to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Cape May County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy is exercising a modified process for the review and approval of Water Quality Management Plan amendments, including Wastewater Management Plans. The Department has identified a number of pending amendments for which minimal modifications at most are expected to be necessary for Department approval. For these amendments, the Department is starting the public comment period earlier than normal in the review process. Amendments noticed under this process have not been fully reviewed by the Department. Be advised that publication of this notice in no way promises that the Department will approve the affected amendments without requirements for modifications. The Department is currently revising the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15); this modified process will be examined on its benefits and may be incorporated within the rules at a later date. The Department reserves the right to require the submittal of additional or modified information in response to public comment or Department review. Where modifications to the amendment are considered minor or non-substantive, the Department will move to a final decision without a new public comment process. However, the Department does reserve the right to require a new public comment process in the case where major modifications occur to the amendment. Any interested party with questions about this process should contact the Office of Land and Water Planning at (609) 633-1179.

The Department is seeking public comment on a proposed amendment to the Cape May County Water Quality Management (WQM) Plan. This amendment proposal was submitted by the New Jersey Highway Authority (NJHA). The amendment proposes connection of the NJHA's Ocean View Service Area in Dennis Township and the Swainton Maintenance Yard and Avalon State Police Barracks in Middle Township to the Seven Mile/Middle sewage treatment plant (STP) in Middle Township. The existing STP which serves the Ocean View Service Area and discharges to a tributary of Ludlam Bay, and the existing on-site sewage disposal system discharging to ground water which serves both the Swainton Maintenance Yard and Avalon State Police Barracks, will be abandoned upon connection to the Seven Mile/Middle STP. The force main and pumping station required for this project will be sized only to handle the wastewater from the three existing facilities specified above.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Cape May County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEPE address cited above with a copy sent to Ms. Barbara Wohlers, New Jersey Highway Authority, Executive Offices, P.O. Box 5050, Woodbridge, New Jersey 07095-5050. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEPE with respect to the amendment request.

Any interested persons may request in writing that the Cape May Planning Board hold a nonadversarial public hearing on the amendment or extend the public comment period in this notice up to 30 additional days. These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of this public notice to Dr. Van Abs at the NJDEPE address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(b)

COMMISSION ON RADIATION PROTECTION

Notice of Meetings of the Advisory Committee on Non-Ionizing Radiation

Take notice that the next two meetings of the Advisory Committee on Non-Ionizing Radiation for the Commission on Radiation Protection will take place on the following dates at the following times and location:

Wednesday, February 2, 1994 at 9:30 A.M. and
Wednesday, March 2, 1994 at 9:30 A.M.
Large Conference Room
729 Alexander Road
Princeton, New Jersey

HEALTH

(c)

GRANT EVALUATION AND REVIEW PROGRAM

Notice of Availability of Directory of Department of Health Grant Programs

Take notice that, in compliance with N.J.S.A. 52:14-34.4 et seq. (P.L. 1987, c.7), the Department of Health hereby publishes notice of grant availability in the Directory of Department of Health Grant Programs. Copies of the Directory can be obtained by contacting the Grant Evaluation and Review Program, Office of Financial and General Services, Department of Health at 609-588-7448.

(d)

THE COMMISSIONER

Notice of Invitation for Certificate of Need Applications

Take notice that in accordance with the provisions of N.J.A.C. 8:33-4.1(a), Bruce Siegel, M.D., M.P.H., Commissioner, New Jersey Department of Health, is inviting certificate of need applications for the following types of health care activities from all health care facilities except general acute care hospitals.

1. Any decrease in the number of licensed beds by licensure and/or health planning category where the reduction in licensed beds will result in a capital expenditure greater than $1,000,000, as referenced at N.J.A.C. 8:33-3.4.

2. Acquisition of a building, new construction and/or renovation of a health care facility which under generally accepted accounting principles results in a cumulative total project cost for all such projects within a fiscal year in excess of $1,000,000, per N.J.A.C. 8:33-3.6, providing that the acquisition of a building, new construction and/or renovation does not include the addition of any new health care services or the addition and/or conversion of beds.

Such certificate of need applications will be received in the Department of Health on the first day of any month in 1994 and will be processed in accordance with full review procedures as set forth in N.J.A.C. 8:33.

Geographic area to be served: Applications will be received from anywhere in the State of New Jersey.

Date applicaton is due: Applications are to be received in the offices of the New Jersey Department of Health's Certificate of Need Program, Room 603, CN 360, Trenton, New Jersey 08625 on the first day of any month in 1994.

Date completeness review decision issued: Upon receipt of all information and documentation requested during completeness review.

Date local advisory boards will review the applications and submit recommendations to the Commissioner and the State Health Planning Board: In accordance with the time-frames set forth in N.J.A.C. 8:33-4.

Date State Health Planning Board will review applications and submit recommendations to the Commissioner: In accordance with the time-frames set forth in N.J.A.C. 8:33-4.

Applications may be requested from and must be filed with:

Certificate of Need Program
New Jersey State Department of Health
CN 360
Trenton, New Jersey 08625-0360
Telephone: 609-292-6552

Applications must also be filed with: Local Advisory Board(s) serving the region of the subject health planning service or facility.

CORRECTIONS

(a)

THE COMMISSIONER

Notice of Receipt of Petition for Rulemaking Inmate Legal Services N.J.A.C. 10A:6-2.2(a)4 and 2.7(c)

Petitioner: Robert Sogluizzo, East Jersey State Prison.

Take notice that on December 9, 1993, the Department of Corrections received a petition for rulemaking at N.J.A.C. 10A:6-2.2(a)4 and 2.7(c), Inmate Legal Services.

The petitioner requests that the Department amend N.J.A.C. 10A:6-2.2(a)4 and 2.7(c) by adding a rule allowing the retention of typewriters for inmates in Disciplinary Detention and Prehearing Detention.

In accordance with the provisions of N.J.S.A. 52:14B-4(f) and N.J.A.C. 1:30-3.6, the Department of Corrections shall subsequently mail to the petitioner, and file with the Office of Administrative Law, a notice of action on the petition.

INSURANCE

(b)

REAL ESTATE COMMISSION

Notice of Action on Petition for Rulemaking N.J.A.C. 11:5-1.16

Petitioner: Laura Trawinski, Clifton, New Jersey

Take notice that on July 22, 1993, the Real Estate Commission (the Commission) received a petition for rulemaking concerning N.J.A.C. 11:5-1.16, the Commission's rules on contracts of sale, leases and listing agreements. Public notice of this petition was published in the September 20, 1993 issue of the New Jersey Register at 25 N.J.R. 4523(c).

In accordance with N.J.A.C. 1:30-3.6 and after thorough review of the petition, the Commission has determined to refer the matter for further deliberations.

Upon completion of the Commission's deliberations, which date will be no later than June 7, 1994, a notice of the Commission's action on the petition will be mailed to the petitioner and published in the New Jersey Register.

A copy of this notice has been mailed to the petitioner, as required by N.J.A.C. 1:30-3.6.

OTHER AGENCIES

(c)

ELECTION LAW ENFORCEMENT COMMISSION

Notice of Public Hearings Public Financing of Primary and General Elections for the Office of Governor: N.J.A.C. 19:25-15 and N.J.A.C. 19:25-16

Take notice that the New Jersey Election Law Enforcement Commission will hold two **public hearings** to seek public comment upon the operation and effect of the 1993 primary and general election Gubernatorial Public Financing Program.

The first public hearing will be held on Tuesday, February 15, 1994 at 10:00 A.M. at the State House, Room 319, West State Street, Trenton, New Jersey.

The second public hearing will be held on Tuesday, March 15, 1994 at 10:00 A.M. at the Maplewood Municipal Building, 574 Valley Street, Maplewood, New Jersey.

Persons wishing to make oral presentations are asked to limit their comments to a 10 minute time period. Presenters should bring a copy of their comments to the hearing for use by the Commission. The hearing record will be kept open for a period of seven days following the date of the second public hearing so that additional written comments can be received.

To reserve time to speak, telephone the Commission offices at (609) 292-8700 by Tuesday, February 8, 1994.

Interested persons may submit written comments until March 22, 1994 to:

Nedda Gold Massar, Esq.
Election Law Enforcement Commission
CN-185
Trenton, New Jersey 08625-0185

(d)

ELECTION LAW ENFORCEMENT COMMISSION

Notice of the Availability of the Quarterly Report of Legislative Agents for the Third Quarter of 1993, Ending September 30, 1993

Take notice that Frederick M. Herrmann, Executive Director of the Election Law Enforcement Commission, in compliance with N.J.S.A. 52:13C-23, hereby publishes Notice of the Availability of the Quarterly Report of Legislative Agents for the third quarter of 1993, accompanied by a Summary of the Quarterly Report.

At the conclusion of the third quarter of 1993, the Notices of Representation filed with this office reflect that 567 individuals are registered as Legislative Agents. Legislative Agents are required by law to submit in writing a Quarterly Report of their activity in attempting to influence legislation and regulation during each calendar quarter. The aforesaid report shall be filed between the first and tenth days of each calendar quarter.

A complete Quarterly Report of Legislative Agents, consisting of the summary and copies of all Quarterly Reports filed by Legislative Agents for the third calendar quarter of 1993, has been filed separately for reference with the following offices: the Office of the Governor, the Office of the Election Law Enforcement Commission, the Office of Legislative Services, and the State Library. Each is available for inspection in accordance with the practices of those offices.

The Summary Report includes the following information:

The names of registered Agents, their registration numbers, their business addresses and whom they represent.

A list of Agents who have filed Quarterly Reports by statutory and compilation deadlines for this quarter.

A list of Agents whose Quarterly Reports were not received by the compilation deadline for this quarter.

Following is a listing of all new Legislative Agents who have filed Notices of Representation during the third calendar quarter of 1993:

No. 833-3 Ronald Johnson representing South Jersey Gas Co.
No. 880-1 Stephen Wiley representing Foundation Aid Districts Assn.
No. 881-1 Jacqueline Walker representing Kean College of NJ
No. 653-2 Patrizia Zita representing Chemical Industry Council of NJ
No. 868-3 Adam Kaufman representing Capitol Public Affairs
No. 174-3 Neil Weisfeld representing Medical Society of NJ
No. 882-1 Russ Chaney representing NJ Assn. of Plumbing, Heating, Cooling Contractors
No. 883-1 John Dorsey representing New Jersey Natural Gas Company
No. 551-11 Beth Sopko representing MWW/Strategic Communications, Inc.
No. 551-12 Terese Kelley representing MWW/Strategic Communications, Inc.
No. 766-5 Terence Welsh representing State Farm Indemnity Company
No. 766-6 Brian Boyden representing State Farm Indemnity Company
No. 18-5 Dennis Testa representing Public School Employees of NJ
No. 884-1 Mary Gonya-Brennan representing Hospital Alliance of New Jersey, Inc.
No. 885-1 John Friedman representing United Services Automobile Association
No. 394-10 James Murphy representing New Jersey Association of School Administrators
No. 394-11 R. Thomas Jannarone representing New Jersey Association of School Administrators
No. 884-2 Sister Jane Frances Brady representing Hospital Alliance of NJ, Inc.
No. 884-3 Jeffrey Moll representing Hospital Alliance of NJ, Inc.
No. 886-1 Daniel Becht representing Municipality of Jersey City
No. 887-1 Caryl Lynn Russo representing Enzon, Inc.
No. 147-2 Penni Wild representing National Federation of Independent Business
No. 888-1 Kelly Tomblin representing Energy Initiatives, Inc.
No. 461-2 Charles Goldstein representing American Federation of State, County and Municipal (AFSCME)
No. 889-1 Joseph Devaney representing Sandoz Pharmaceuticals Corporation
No. 890-1 John Conaty representing United Parcel Service
No. 891-1 Thomas Fitzgerald representing Household International
No. 813-3 Judith Cusick representing Schering Corporation
No. 19-8 Michael A. Egenton representing New Jersey State Chamber of Commerce
No. 863-2 Nancy Bradish representing Blue Cross and Blue Shield of New Jersey Inc.
No. 552-2 Frank Thomas Sole representing Commerce & Industry Association of NJ
No. 45-9 Richard Siderko representing New Jersey Savings League
No. 892-1 Daniel Ellis, Independent Agent
No. 893-1 Larry Gephart representing Exxon Biomedical Sciences, Inc.

Following is a listing of all Legislative Agents who have filed Notices of Termination during the third calendar quarter of 1993.

Legislative Agent	Registration Number
Joseph Ackourey	871-1
Kelly Astarita	644-1
William Baxter	710-1
M. Paige Berry	828-2
Mary Kathryn Brennan	260-1
James Burnte	867-1
Maeve Cannon	828-6
Daniel Caramagno	816-1
Lester Damron	814-2
Dr. Jack Eisenstein	394-9
Dr. Jean Emmons	394-2
Robin Frey	756-10
John Friedman	165-1
Kathleen Galop	699-1
Ronald Gordon	607-1
Michael Herbert	828-1
David Himelman	828-5
Matthew Holland	551-8
Patrick Hollister	814-1
Carla Israel	653-1
Ronald Johnson	19-6
Timothy Kelsey	555-1
Patrick Kennedy	828-4
Barbara Klag	813-1
Betty Kraemer	530-2
Donald Linky	763-1
Richard Manning	443-1
Vincent Miller	368-1
Carol Reistetter	798-1
Janet Remetta	202-1
Dennis Riley	625-1
Marguerite Schaffer	810-1
Stephen St. Hilaire	756-8
Sheryl Stitt	583-4
Rob Stuart	602-6
Neil Yoskin	828-8

For further information, contact the staff of the Commission at (609) 292-8700.

REGISTER INDEX OF RULE PROPOSALS AND ADOPTIONS

The research supplement to the New Jersey Administrative Code

A CUMULATIVE LISTING OF CURRENT PROPOSALS AND ADOPTIONS

The **Register Index of Rule Proposals and Adoptions** is a complete listing of all active rule proposals (with the exception of rule changes proposed in this Register) and all new rules and amendments promulgated since the most recent update to the Administrative Code. Rule proposals in this issue will be entered in the Index of the next issue of the Register. **Adoptions promulgated in this Register have already been noted in the Index by the addition of the Document Number and Adoption Notice N.J.R. Citation next to the appropriate proposal listing.**

Generally, the key to locating a particular rule change is to find, under the appropriate Administrative Code Title, the N.J.A.C. citation of the rule you are researching. If you do not know the exact citation, scan the column of rule descriptions for the subject of your research. To be sure that you have found all of the changes, either proposed or adopted, to a given rule, scan the citations above and below that rule to find any related entries.

At the bottom of the index listing for each Administrative Code Title is the Transmittal number and date of the latest looseleaf update to that Title. Updates are issued monthly and include the previous month's adoptions, which are subsequently deleted from the Index. To be certain that you have a copy of all recent promulgations not yet issued in a Code update, retain each Register beginning with the December 6, 1993 issue.

If you need to retain a copy of all currently proposed rules, you must save the last 12 months of Registers. A proposal may be adopted up to one year after its initial publication in the Register. Failure to adopt a proposed rule on a timely basis requires the proposing agency to resubmit the proposal and to comply with the notice and opportunity-to-be-heard requirements of the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.), as implemented by the Rules for Agency Rulemaking (N.J.A.C. 1:30) of the Office of Administrative Law. If an agency allows a proposed rule to lapse, "Expired" will be inserted to the right of the Proposal Notice N.J.R. Citation in the next Register following expiration. Subsequently, the entire proposal entry will be deleted from the Index. See: N.J.A.C. 1:30-4.2(c).

Terms and abbreviations used in this Index:

N.J.A.C. Citation. The New Jersey Administrative Code numerical designation for each proposed or adopted rule entry.

Proposal Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of a proposed amendment or new rule.

Document Number. The Registry number for each adopted amendment or new rule on file at the Office of Administrative Law, designating the year of promulgation of the rule and its chronological ranking in the Registry. As an example, R.1993 d.1 means the first rule filed for 1993.

Adoption Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of an adopted amendment or new rule.

Transmittal. A series number and supplement date certifying the currency of rules found in each Title of the New Jersey Administrative Code: Rule adoptions published in the Register after the Transmittal date indicated do not yet appear in the loose-leaf volumes of the Code.

N.J.R. Citation Locator. An issue-by-issue listing of first and last pages of the previous 12 months of Registers. Use the locator to find the issue of publication of a rule proposal or adoption.

MOST RECENT UPDATE TO THE ADMINISTRATIVE CODE: SUPPLEMENT NOVEMBER 15, 1993

NEXT UPDATE: SUPPLEMENT DECEMBER 20, 1993

Note: If no changes have occurred in a Title during the previous month, no update will be issued for that Title.

N.J.R. CITATION LOCATOR

If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register	If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register
25 N.J.R. 219 and 388	January 19, 1993	25 N.J.R. 3277 and 3582	August 2, 1993
25 N.J.R. 389 and 616	February 1, 1993	25 N.J.R. 3583 and 3884	August 16, 1993
25 N.J.R. 619 and 736	February 16, 1993	25 N.J.R. 3885 and 4360	September 7, 1993
25 N.J.R. 737 and 1030	March 1, 1993	25 N.J.R. 4361 and 4540	September 20, 1993
25 N.J.R. 1031 and 1308	March 15, 1993	25 N.J.R. 4541 and 4694	October 4, 1993
25 N.J.R. 1309 and 1620	April 5, 1993	25 N.J.R. 4695 and 4812	October 18, 1993
25 N.J.R. 1621 and 1796	April 19, 1993	25 N.J.R. 4813 and 4980	November 1, 1993
25 N.J.R. 1797 and 1912	May 3, 1993	25 N.J.R. 4981 and 5382	November 15, 1993
25 N.J.R. 1913 and 2150	May 17, 1993	25 N.J.R. 5383 and 5728	December 6, 1993
25 N.J.R. 2151 and 2620	June 7, 1993	25 N.J.R. 5729 and 6084	December 20, 1993
25 N.J.R. 2621 and 2794	June 21, 1993	26 N.J.R. 1 and 280	January 3, 1994
25 N.J.R. 2795 and 3050	July 6, 1993	26 N.J.R. 281 and 520	January 18, 1994
25 N.J.R. 3051 and 3276	July 19, 1993		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
ADMINISTRATIVE LAW—TITLE 1				
1:10-1.1, 9.1, 9.2, 14.1, 14.2, 14.3, 18.1	Family Development hearings	25 N.J.R. 3888(a)		
1:13A	Lemon law hearings	25 N.J.R. 5387(a)		
1:14-10	BRC ratemaking hearings: discovery	26 N.J.R. 3(a)		
	Most recent update to Title 1: TRANSMITTAL 1993-2 (supplement September 20, 1993)			
AGRICULTURE—TITLE 2				
2:2	Animal Disease Control Program	25 N.J.R. 5387(b)		
2:6	Animal health: biologics for diagnostic or therapeutic purposes	25 N.J.R. 4985(a)		
2:68	Commercial feeding stuffs	25 N.J.R. 3889(a)	R.1993 d.606	25 N.J.R. 5462(a)
2:69	Commercial fertilizers and soil conditioners	25 N.J.R. 4544(a)	R.1993 d.688	25 N.J.R. 5917(a)
2:69-1.11	Commercial values of primary plant nutrients	25 N.J.R. 3585(a)	R.1993 d.600	25 N.J.R. 5917(b)
2:76-6.11	Farmland Preservation Program: acquisition of development easements	25 N.J.R. 3890(a)	R.1994 d.43	26 N.J.R. 350(a)
2:76-6.11	Farmland Preservation Program: correction to proposal and extension of comment period regarding acquisition of development easements	25 N.J.R. 4697(a)		
	Most recent update to Title 2: TRANSMITTAL 1993-6 (supplement November 15, 1993)			
BANKING—TITLE 3				
3:3-2.2, 2.3	Release of bank examination reports to independent auditors	25 N.J.R. 4819(a)	R.1994 d.49	26 N.J.R. 351(a)
3:4-1.6	Capital for interim conversion in merger or acquisition	25 N.J.R. 4545(a)	R.1993 d.661	25 N.J.R. 5917(c)
3:4-3	Banking institutions: sale of alternative investments	25 N.J.R. 5733(a)		
3:6-15.2	Disqualification of savings bank directors	25 N.J.R. 3586(b)		
3:11-7.11	Disqualification of bank directors	25 N.J.R. 3586(b)		
3:14	Bank service corporations	26 N.J.R. 3(b)		
3:38-1.1, 1.10, 5.1	Mortgage banker non-servicing	25 N.J.R. 1035(a)		
3:38-5.3	Mortgage referrals by real estate agents	26 N.J.R. 6(a)		
3:41-2.1, 11	Cemetery Board: location of interment spaces and path access	25 N.J.R. 623(a)	R.1993 d.632	25 N.J.R. 5462(b)
3:41-5.1	Cemetery Board: cemetery company price lists	25 N.J.R. 4819(b)	R.1994 d.19	26 N.J.R. 197(a)
3:41-12	Cemetery Board: service contractors and service contracts	26 N.J.R. 6(b)		
	Most recent update to Title 3: TRANSMITTAL 1993-8 (supplement November 15, 1993)			
CIVIL SERVICE—TITLE 4				
	Most recent update to Title 4: TRANSMITTAL 1992-1 (supplement September 21, 1992)			
PERSONNEL—TITLE 4A				
4A:1-5	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1314(c)	R.1993 d.614	25 N.J.R. 5464(a)
4A:1-5.3, 5.4	Coordinator address: administrative change	_____	_____	26 N.J.R. 197(b)
4A:2-2.11	Bankruptcy interest: administrative correction	_____	_____	26 N.J.R. 198(a)
4A:3-4.10	State service: demotional pay adjustments	25 N.J.R. 4821(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
4A:4-2.2, 2.14	Equal employment opportunity	25 N.J.R. 4821(b)		
4A:4-2.9	Make-up examinations	25 N.J.R. 4823(a)		
4A:4-7.8	Voluntary demotions	25 N.J.R. 4823(b)		
4A:6-1.2, 1.6, 1.11, 1.12, 1.13	Leaves of absence	25 N.J.R. 4824(a)		
4A:6-1.3	Equal employment opportunity	25 N.J.R. 4821(b)		
4A:7-1.1, 2.1, 2.2, 2.3, 3.1	Equal employment opportunity	25 N.J.R. 4821(b)		

Most recent update to Title 4A: TRANSMITTAL 1993-7 (supplement November 15, 1993)

COMMUNITY AFFAIRS—TITLE 5

5:18-1.4, 1.5, 2.1, 2.3, 2.5, 2.6, 2.11, 2.14, 4.1, 4.3	Uniform Fire Code	25 N.J.R. 4363(a)	R.1993 d.628	25 N.J.R. 5466(a)
5:18-3.2, 3.3, 3.13, 3.19, App. 3A	Fire Prevention Code: junk yards, recycling centers, and other exterior storage sites	25 N.J.R. 1315(b)		
5:18-4.3, 4.7	Fire Safety Code: fire suppression systems in hospitals and nursing homes	25 N.J.R. 1316(a)		
5:18A-1.4, 2.2, 2.3, 2.5–2.11, 3.3, 3.4, 3.6, 4.2–4.6, 4.9, 4.10	Fire Code enforcement	25 N.J.R. 4363(a)	R.1993 d.628	25 N.J.R. 5466(a)
5:18B-2.8	High level alarms	25 N.J.R. 4363(a)	R.1993 d.628	25 N.J.R. 5466(a)
5:18C-1.4, 1.5, 1.7, 1.8, 1.9, 2.3	Fire service training and certification	25 N.J.R. 4363(a)	R.1993 d.628	25 N.J.R. 5466(a)
5:23-2.6, 2.14, 2.23, 3.2, 3.4, 3.8A, 3.11A, 3.14–3.18, 3.20, 3.20A, 3.21, 4.3A, 4A.8, 4A.11, 12.2	Uniform Construction Code: subcodes	25 N.J.R. 3891(a)	R.1993 d.662	25 N.J.R. 5918(a)
5:23-2.17A	Uniform Construction Code: reroofing work	25 N.J.R. 4546(a)	R.1993 d.663	25 N.J.R. 5927(a)
5:23-2.18A, 3.11, 4.20	UCC: utility load management device permits; mausoleum plan review; Department fees	25 N.J.R. 4546(b)	R.1994 d.28	26 N.J.R. 352(a)
5:23-2.22, 4.18, 4.20, 4.22, 4.26, 4.29, 4.31, 4.39, 4A.1-4A.5, 4A.7-4A.2, 4B, 4C	Uniform Construction Code: industrialized/modular buildings	25 N.J.R. 5388(a)		
5:23-4.4, 4.5, 4.5A, 4.12, 4.14, 4.18, 4.20	Uniform Construction Code: private on-site inspection agencies	25 N.J.R. 2162(a)		
5:23-4.18	UCC: subcode training registration fee	25 N.J.R. 4548(a)	R.1993 d.665	25 N.J.R. 5928(a)
5:25-5.5	New home warranties and builder registration: claims procedure	25 N.J.R. 4986(a)		
5:27-1.3, 1.4, 1.6, 2.1, 12.2	Rooming and boarding houses: administrative corrections	———	———	25 N.J.R. 5928(b)
5:28	Foreword State Housing Code: administrative correction	———	———	25 N.J.R. 5928(b)
5:80-8	Housing and Mortgage Finance Agency: occupancy income requirements	26 N.J.R. 8(a)		
5:80-23.7, 23.9	Housing Incentive Note Purchase Program: fees; subordinate financing	26 N.J.R. 9(a)		
5:80-23.9	Housing and Mortgage Finance Agency: Housing Incentive Note Purchase Program fees	25 N.J.R. 3053(a)		
5:80-24	Housing and Mortgage Finance Agency: Lease-Purchase Program	25 N.J.R. 4826(a)		
5:80-26.19	Housing and Mortgage Finance Agency: affordable housing controls	25 N.J.R. 4369(a)	R.1993 d.640	25 N.J.R. 5471(a)
5:80-29	Housing and Mortgage Finance Agency: investment of housing project funds	25 N.J.R. 4830(a)		
5:80-32	Housing and Mortgage Finance Agency: housing investment sales	25 NJ.R. 4828(a)		
5:91-1.3	Counseling on Affordable Housing: substantive rules	25 N.J.R. 5763(a)		
5:92-1.1, 13.1	Council on Affordable Housing: substantive rules	25 N.J.R. 5763(a)		
5:93	Council on Affordable Housing: substantive rules	25 N.J.R. 5763(a)		

Most recent update to Title 5: TRANSMITTAL 1993-11 (supplement November 15, 1993)

MILITARY AND VETERANS' AFFAIRS—TITLE 5A

5A:7-1	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1317(a)	R.1993 d.615	25 N.J.R. 5472(a)

Most recent update to Title 5A: TRANSMITTAL 1992-2 (supplement September 21, 1992)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
EDUCATION—TITLE 6				
6:1 et seq.	Title 6, New Jersey Administrative Code: opportunity for public comment	25 N.J.R. 4369(b)		
6:2	Appeals to State Board of Education	25 N.J.R. 4548(b)	R.1994 d.17	26 N.J.R. 198(b)
6:28	Special education	25 N.J.R. 5734(a)		
	Most recent update to Title 6: TRANSMITTAL 1993-8 (supplement November 15, 1993)			
ENVIRONMENTAL PROTECTION AND ENERGY—TITLE 7				
7:0	Green glass marketing and recycling: request for public input on feasibility study	25 N.J.R. 1654(a)		
7:0	Regulated Medical Waste Management Plan: public hearing and opportunity for comment	25 N.J.R. 1654(b)		
7:0	Site Remediation Program: analysis of strict, joint and several liability under the New Jersey Spill Compensation Act	25 N.J.R. 3694(a)		
7:1E	Discharges of petroleum and other hazardous substances: request for public comment on draft amendments	25 N.J.R. 2636(a)		
7:1G	Worker and Community Right to Know	26 N.J.R. 123(a)		
7:1G-1–5, 7	Worker and Community Right to Know	25 N.J.R. 1631(a)	R.1994 d.3	26 N.J.R. 200(a)
7:1I	Sanitary Landfill Facility Closure and Contingency Fund: processing of damage claims	25 N.J.R. 5116(a)		
7:1K-1.5, 3.1, 3.4, 3.9-3.11, 4.3, 4.5, 4.7, 5.1, 5.2, 6.1, 6.2, 7.2, 7.3, 9.2-9.5, 9.7, 12.6-12.9	Pollution Prevention Program requirements	25 N.J.R. 1849(a)		
7:2-2.20, 3.6, 6.4, 8.4, 8.6, 10.2, 16.5, 17.1, 17.3, 17.4, 17.5	State Park Service Code	25 N.J.R. 2799(b)	R.1993 d.657	25 N.J.R. 5953(a)
7:4B	Historic Preservation Revolving Loan Program	25 N.J.R. 748(a)	R.1993 d.637	25 N.J.R. 5694(a)
7:7A-1.4, 2.7	Freshwater Wetlands Protection Act rules: definition of project	25 N.J.R. 1642(a)	R.1993 d.646	25 N.J.R. 5954(a)
7:9-1.1	Treatment works approval, sewer bans and sewer ban exemptions	25 N.J.R. 3282(a)		
7:9-4 (7:9B)	Surface water quality standards; draft Practical Quantitation Levels; total phosphorus limitations and criteria: extension of comment periods and notice of roundtable discussion	25 N.J.R. 404(a)		
7:9-4 (7:9B-1), 6.3	Surface water quality standards	24 N.J.R. 3983(a)	R.1993 d.610	25 N.J.R. 5569(a)
7:9-4.14, 4.15 (7:9B-1.14, 1.15)	Surface water quality standards: administrative corrections to proposal	24 N.J.R. 4471(a)		
7:9-4.15	Water surface quality standards: Wallkill River	25 N.J.R. 3755(a)		
7:11-2.1-2.4, 2.9, 2.10, 2.13	Delaware and Raritan Canal—Spruce Run/Round Valley Reservoirs System: sale of water	25 N.J.R. 5742(a)		
7:11-4.3, 4.4	Sale of water from Manasquan Reservoir Water Supply System: administrative corrections	———	———	25 N.J.R. 5956(a)
7:11-4.3, 4.4, 4.9	Manasquan Reservoir Water Supply System: sale of water	25 N.J.R. 5744(a)		
7:13-7.1	Delaware River, Pohatcong Township: flood plain redelineation	25 N.J.R. 4370(a)	R.1994 d.10	26 N.J.R. 212(a)
7:13-7.1	Overpeck Creek, Englewood: flood plain redelineation	25 N.J.R. 4371(a)	R.1994 d.11	26 N.J.R. 212(b)
7:13-7.1	Poplar Brook, Deal: flood plain redelineation	25 N.J.R. 4372(a)	R.1994 d.9	26 N.J.R. 211(a)
7:14-8.3	Clean Water Enforcement Act: financial assurance for penalty payment schedules	25 N.J.R. 5395(a)		
7:14A	NJPDES Program: opportunity for interested party review of permitting system	25 N.J.R. 411(a)		
7:14A	NJPDES Program: extension of comment period for interested party review of permitting system	25 N.J.R. 1863(a)		
7:14A-1.9, 3.14	Surface water quality standards	24 N.J.R. 3983(a)	R.1993 d.610	25 N.J.R. 5569(a)
7:14A-1.9, 12, 22, 23	Treatment works approval, sewer bans and exemptions	25 N.J.R. 3282(a)		
7:14A-2.15, 6.14, 6.17, 12.4	Contaminated site remediation: NJPDES permit program	26 N.J.R. 158(a)		
7:14B-1.6, 2.2, 2.6, 2.7, 2.8, 3.1–3.8	Underground Storage Tanks Program fees	25 N.J.R. 1363(a)		
7:15-5.18	Treatment works approval, sewer bans and exemptions	25 N.J.R. 3282(a)		
7:20A	Water usage certifications for agricultural or horticultural purposes	25 N.J.R. 3956(a)	R.1994 d.12	26 N.J.R. 212(c)
7:25-7.13, 14.1, 14.2, 14.4–14.8, 14.10–14.13	Crab management	25 N.J.R. 4831(a)		
7:25-18.1, 18.14	Summer flounder permit conditions	25 N.J.R. 2167(a)	R.1994 d.44	26 N.J.R. 353(a)
7:25-18.5, 18.6, 18.12	Delaware Bay gill net permits	25 N.J.R. 5397(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
7:25A-1.2, 1.4, 1.9, 4.3	Oyster management	25 N.J.R. 754(a)		
7:26-1.4, 9.3	Hazardous waste management: satellite accumulation areas	25 N.J.R. 1864(a)		
7:26-6.6	Procedure for modification of waste flows	25 N.J.R. 991(a)		
7:26-8.8, 8.12, 8.19	Handling of substances displaying the Toxicity Characteristic	25 N.J.R. 753(a)		
7:26-12.3	Hazardous waste management: interim status facilities	24 N.J.R. 4253(a)	R.1993 d.638	25 N.J.R. 5664(a)
7:26B-1.3, 1.10, 1.11, 1.12	Environmental Cleanup Responsibility Act Program fees	25 N.J.R. 1375(a)		
7:26C	Site Remediation Program: opportunity for comment on draft remedial priority system	25 N.J.R. 4551(c)		
7:27-1, 8, 18, 22	Air pollution control: facility operating permits	25 N.J.R. 3963(a)		
7:27-1, 8, 18, 21, 22	Air pollution control: extension of comment period regarding facility operating permits, emission statements, and penalties	25 N.J.R. 4836(a)		
7:27-1.4, 2.1, 8.1, 8.2, 16, 17.1, 17.3, 17.4, 23.1-23.7, 25.1, 25.7	Air pollution by volatile organic compounds: control and prohibition	25 N.J.R. 3339(a)	R.1993 d.666	25 N.J.R. 6002(a)
7:27-1.4, 2.1, 8.1, 8.2, 16, 17.1, 17.3, 17.4, 23.1–23.7, 25.1, 25.7	Air pollution control: extension of comment period	25 N.J.R. 4551(a)		
7:27-15.1, 15.2, 15.4-15.10	Air quality management: enhanced inspection and maintenance program	25 N.J.R. 3322(a)		
7:27-15.1, 15.4	Enhanced Inspection and Maintenance (I/M) program	25 N.J.R. 5400(a)		
7:27-15.4	Air quality management: enhanced Inspection and Maintenance program	25 N.J.R. 5130(a)		
7:27-19	Control and prohibition of air pollution from oxides of nitrogen	25 N.J.R. 631(a)	R.1993 d.682	25 N.J.R. 5957(a)
7:27-21.1–21.5, 21.8, 21.9, 21.10	Air pollution control: facility emission statements	25 N.J.R. 4033(a)		
7:27-25.1, 25.3, 25.4, 25.9, 25.10, 25.11, 25.12	Oxygenated fuels program	25 N.J.R. 4039(a)		
7:27-26	Low Emissions Vehicle Program	25 N.J.R. 1381(a)		
7:27A-3.2, 3.5, 3.10	Air pollution control: administrative penalties and requests for adjudicatory hearings	25 N.J.R. 4045(a)		
7:27A-3.2, 3.10	Air pollution civil administrative penalties	25 N.J.R. 3339(a)	R.1993 d.666	25 N.J.R. 6002(a)
7:27A-3.2, 3.10	Air pollution civil administrative penalties: extension of comment period	25 N.J.R. 4551(a)		
7:27A-3.5, 3.10	Control and prohibition of air pollution from oxides of nitrogen: civil administrative penalties	25 N.J.R. 631(a)	R.1993 d.682	25 N.J.R. 5957(a)
7:27A-3.10	Air pollution control: facility emission statement penalties	25 N.J.R. 4033(a)		
7:27A-3.10	Oxygenated fuels program penalties	25 N.J.R. 4039(a)		
7:27A-3.10	Air quality management: enhanced Inspection and Maintenance program	25 N.J.R. 5130(a)		
7:27A-3.10	Enhanced I/M program	25 N.J.R. 5400(a)		
7:27B-3.1, 3.10	Air pollution sampling and analytical procedures	25 N.J.R. 3339(a)	R.1993 d.666	25 N.J.R. 6002(a)
7:27B-3.1, 3.10	Air pollution sampling and analytical procedures: extension of comment period	25 N.J.R. 4551(a)		
7:27B-4.1, 4.5–4.10	Air quality management: enhanced inspection and maintenance program	25 N.J.R. 3322(a)		
7:27B-4.1, 4.5, 4.6, 4.9	Enhanced I/M program	25 N.J.R. 5400(a)		
7:27B-4.5, 4.6, 4.9	Air quality management: enhanced Inspection and Maintenance program	25 N.J.R. 5130(a)		
7:28-1.4	Radiation protection: administrative corrections	_____	_____	25 N.J.R. 5665(a)
7:28-48	Non-ionizing radiation producing sources: registration fees	25 N.J.R. 5422(a)		
7:36	Green Acres Program: opportunity to review draft rule revisions	25 N.J.R. 1473(a)		
7:36	Green Acres Grant Program	25 N.J.R. 3405(a)	R.1993 d.609	25 N.J.R. 5666(a)
7:45	Delaware and Raritan Canal State Park Review Zone	25 N.J.R. 4836(b)		
7:50-2, 3, 4, 5, 6, 7	Pinelands Comprehensive Management Plan	26 N.J.R. 165(a)		
	Most recent update to Title 7: TRANSMITTAL 1993-11 (supplement November 15, 1993)			
HEALTH—TITLE 8				
8:2A-1	Access to death records	25 N.J.R. 3115(a)	R.1993 d.667	25 N.J.R. 6012(a)
8:21-10.1, 10.2, 10.4, 10.6, 10.12	Milk and fluid milk products	25 N.J.R. 4373(a)	R.1993 d.689	25 N.J.R. 6013(a)
8:24	Packing of refrigerated foods in reduced oxygen packages by retail establishments: preproposal	25 N.J.R. 660(b)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
8:31B-2.1, 2.3, 2.4, 2.5	Hospital reporting of uniform bill—patient summaries (inpatient)	26 N.J.R. 10(a)		
8:31B-3.3, 3.70	Health care financing: monitoring and reporting	26 N.J.R. 12(a)		
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8:33E	Cardiac diagnostic facilities and surgery centers: certificate of need	25 N.J.R. 3712(a)	R.1993 d.670	25 N.J.R. 6019(b)
8:33H	Long-term care services: certificate of need policy	25 N.J.R. 3719(a)	R.1993 d.671	25 N.J.R. 6031(a)
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8:44-2.11	Clinical laboratories: reporting by supervisors	25 N.J.R. 3751(a)	R.1994 d.36	26 N.J.R. 362(a)
8:59-5.6	Worker and Community Right to Know: exclusions from labeling requirements	25 N.J.R. 3441(a)	R.1994 d.21	26 N.J.R. 217(a)
8:59-App. A, B	Worker and Community Right to Know Act: preproposal concerning Hazardous Substance List and Special Health Hazard Substance List	25 N.J.R. 792(a)		
8:71	Interchangeable drug products (see 24 N.J.R. 2557(b), 3173(a), 4260(b); 25 N.J.R. 582(a))	24 N.J.R. 1674(a)	R.1993 d.226	25 N.J.R. 1970(b)
8:71	Interchangeable drug products (see 24 N.J.R. 3174(c), 3728(a), 4262(a); 25 N.J.R. 583(a))	24 N.J.R. 2414(b)	R.1993 d.338	25 N.J.R. 2882(b)
8:71	Interchangeable drug products (see 24 N.J.R. 4261(a); 25 N.J.R. 582(b))	24 N.J.R. 2997(a)	R.1993 d.225	25 N.J.R. 1970(a)
8:71	Interchangeable drug products (see 25 N.J.R. 580(b), 2883(a))	24 N.J.R. 4009(a)	R.1993 d.468	25 N.J.R. 4497(a)
8:71	Interchangeable drug products (see 25 N.J.R. 1221(a), 1969(c), 2882(a), 4496(b), 6061(b))	25 N.J.R. 55(a)	R.1994 d.38	26 N.J.R. 363(a)
8:71	Interchangeable drug products (see 25 N.J.R. 1970(c), 2881(b), 4497(b))	25 N.J.R. 875(a)	R.1993 d.673	25 N.J.R. 6060(b)
8:71	Interchangeable drug products (see 25 N.J.R. 2881(a), 4496(a))	25 N.J.R. 1814(b)	R.1993 d.676	25 N.J.R. 6061(a)
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8:71	Interchangeable drug products (see 25 N.J.R. 4495(b), 6062(a))	25 N.J.R. 2802(b)	R.1994 d.40	26 N.J.R. 364(b)
8:71	Interchangeable drug products (see 25 N.J.R. 6060(c))	25 N.J.R. 3906(a)	R.1994 d.39	26 N.J.R. 364(a)
8:71	List of Interchangeable Drug Products	25 N.J.R. 4377(a)	R.1993 d.674	25 N.J.R. 6060(a)
8:71	Interchangeable drug products	25 N.J.R. 4844(a)	R.1994 d.37	26 N.J.R. 362(b)
8:71	List of Interchangeable Drug Products	26 N.J.R. 13(b)		
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9:5-2.1, 2.2, 2.3, 2.5, 2.7	Job training program: unemployed persons tuition waiver	25 N.J.R. 3593(a)		
9:7-9	Paul Douglas Teacher Scholarship Program	25 N.J.R. 3594(a)	R.1994 d.13	26 N.J.R. 219(a)
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10:38-1.4, 2.1, 2.2, 3.3, 3.4, 3.6, 3.8, 4.3, 5.2, 7.2, 7.4, 7.5, App. C, E, G	Interim Assistance Program for discharged State psychiatric hospital clients	25 N.J.R. 3697(a)		
10:39	Repeal (see 10:37A)	25 N.J.R. 2672(a)		
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10:49-19.1, 19.4, 19.7, 19.11	State-defined HMOs	25 N.J.R. 4793(a)	R.1994 d.4	26 N.J.R. 224(a)
10:51-5.6	Pharmaceutical services: income eligibility limits	25 N.J.R. 3407(a)	R.1993 d.608	25 N.J.R. 5528(b)
10:52-1.9, 1.13	Reimbursement methodology for distinct units in acute care hospitals and for private psychiatric hospitals	24 N.J.R. 4477(a)	R.1993 d.647	25 N.J.R. 5947(a)
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10:60-1.1–1.17, 2.2, 2.4, 2.5, 2.8, 2.9, 2.10, 2.12, 2.14, 2.15, 2.16, 3.2, 3.3, 3.6, 4.2, 6, App. A, H	Home Care Services Manual	25 N.J.R. 5167(a)	R.1994 d.41	26 N.J.R. 364(c)
10:62	Vision care services	25 N.J.R. 3907(a)	R.1994 d.6	26 N.J.R. 225(a)
10:66	Independent clinic services: Medicaid program services	25 N.J.R. 4379(a)	R.1993 d.641	25 N.J.R. 5528(c)
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10:69A-1.2, 6.2	PAAD income eligibility limits	25 N.J.R. 3407(a)	R.1993 d.608	25 N.J.R. 5528(b)
10:69A-1.2, 6.2	PAAD eligibility: exclusion of reparation payments as countable income	25 N.J.R. 5750(a)		
10:69B-4.2	Lifeline programs: income eligibility limits	25 N.J.R. 3407(a)	R.1993 d.608	25 N.J.R. 5528(b)
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10:81-10.7, 10.8	Refugee Resettlement Program: eligibility limitations	25 N.J.R. 3919(a)	R.1993 d.648	25 N.J.R. 5948(a)
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10:81-11.7, 11.9	Non-AFDC child support orders	25 N.J.R. 2816(a)	R.1993 d.649	25 N.J.R. 5949(a)
10:81-11.7, 11.9	Automated Child Support Enforcement System	26 N.J.R. 84(a)		
10:81-11.9	CWA/CSP Unit paternity services: administrative corrections	————	————	25 N.J.R. 5950(a)
10:81-11.21	Review and adjustment of child support orders in AFDC, foster care, and Medicaid Only cases	25 N.J.R. 2818(a)	R.1993 d.627	25 N.J.R. 5567(a)
10:83-1.11	New Jersey Supplemental Security Income payment levels: administrative change	————	————	26 N.J.R. 235(b)
10:84	Administration of public assistance programs: agency action on public hearing	24 N.J.R. 4480(a)		
10:84-1	Administration of public assistance programs	24 N.J.R. 4480(b)	R.1993 d.611	26 N.J.R. 374(a)
10:87	Food Stamp Program	25 N.J.R. 4697(b)	R.1994 d.42	26 N.J.R. 377(a)
10:89-2.3, 3.1, 3.2, 3.3	Home Energy Assistance: income eligibility guidelines	Emergency (expires 2-7-94)	R.1994 d.20	26 N.J.R. 256(a)
10:97-1.3, 3.1	Commission for the Blind and Visually Impaired: licensing procedure for Business Enterprise Program	25 N.J.R. 4551(d)	R.1994 d.27	26 N.J.R. 378(a)
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10:140	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1326(a)		
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10A:2-2.2	Inmate accounts: transaction fees	25 N.J.R. 4849(a)	R.1994 d.8	26 N.J.R. 235(a)
10A:3-1.4, 2.3	Inmate keep separate status	25 N.J.R. 4702(a)	R.1993 d.679	25 N.J.R. 5929(a)
10A:9-5.5	Restoration to inmates of forfeited commutation credits	25 N.J.R. 4553(a)	R.1993 d.636	25 N.J.R. 5476(a)
10A:22	Inmate and parolee records	25 N.J.R. 5754(a)		
10A:31-6.13	Reimbursement for copying costs	25 N.J.R. 4552(a)	R.1993 d.635	25 N.J.R. 5475(a)
10A:33	Manual of Standards for Juvenile Detention Commitment Programs	25 N.J.R. 5749(a)		

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10A:71-3.47	State Parole Board: victim input	25 N.J.R. 4705(a)		
10A:71-7.16	State Parole Board: general conditions of parole and future eligibility upon revocation	25 N.J.R. 3597(a)	R.1994 d.18	26 N.J.R. 236(a)
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11:1-7	New Jersey Property-Liability Insurance Guaranty Association: plan of operation	25 N.J.R. 1045(a)		
11:1-31	Surplus lines insurer eligibility	25 N.J.R. 1819(a)		
11:1-34	Surplus lines: exportable list procedures	24 N.J.R. 4331(a)	R.1994 d.7	26 N.J.R. 236(b)
11:1-37	Public adjusters' licensing	25 N.J.R. 5432(a)		
11:2-17.11	Payment of third-party claims: written notice by insurer to claimant	25 N.J.R. 3921(a)	R.1993 d.681	25 N.J.R. 5929(b)
11:3-3	Limited assignment distribution servicing carriers	25 N.J.R. 1327(b)		
11:3-15.7	Automobile insurance Coverage Selection Form	26 N.J.R. 85(a)		
11:3-16.10	Private passenger automobile insurance: rate filing requirements	25 N.J.R. 4436(a)	R.1994 d.46	26 N.J.R. 378(b)
11:3-20.5, 20A.1	Automobile insurers: reporting apportioned share of MTF losses in excess profits reports; ratio limiting the effect of negative excess investment income	25 N.J.R. 1829(a)	R.1994 d.24	26 N.J.R. 241(a)
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11:3-36.6	Automobile physical damage insurance inspection procedures	25 N.J.R. 5756(a)		
11:3-42.2, 42.9	Producer Assignment Program: request for exemption	25 N.J.R. 2215(a)		
11:3-42.12, 42.17	Producer assignment program: administrative corrections	———	———	25 N.J.R. 5930(a)
11:4-37	Selective contracting arrangements of insurers	25 N.J.R. 4554(b)	R.1994 d.45	26 N.J.R. 381(a)
11:5-1.3	Real Estate Commission: broker pre-licensure requirements	25 N.J.R. 4849(b)		
11:5-1.3, 1.10, 1.27, 1.28, 1.31	Real Estate Commission: extension of comment periods on various licensure and prelicensure proposals	25 N.J.R. 5099(a)		
11:5-1.10	Real Estate Commission: compensation and licensure requirement	25 N.J.R. 4851(a)		
11:5-1.27	Real Estate Commission: educational requirements for broker and salesperson licensure	25 N.J.R. 4852(a)		
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11:13-7.4, 7.5	Commercial lines: exclusions from coverage; refiling policy forms	25 N.J.R. 1053(a)		
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11:20-17, App. Exh. L	Standard health benefits plan: enrollment status reports	26 N.J.R. 90(a)		
11:21-1.2, 4.1, App. Exhibits	Small Employer Health Benefits Program	25 N.J.R. 5017(a)	R.1994 d.47	26 N.J.R. 400(a)
11:21-1.3, 1.4, 1.5, 6, 7, 7A, 17, 18, App. Exh. N–T	Small Employer Health Benefits Program	25 N.J.R. 4437(a)	R.1993 d.644	25 N.J.R. 5668(a)
11:21-2	Small Employer Health Benefits Program: Plan of Operation	25 N.J.R. 4563(a)	R.1994 d.48	26 N.J.R. 391(a)
11:21-2	Small Employer Health Benefits Program: public hearing on Plan of Operation	25 N.J.R. 4678(a)		
11:21-9	Small Employer Health Benefits Program: informational rate filings	25 N.J.R. 5757(a)	R.1994 d.25	26 N.J.R. 245(a)
11:21-15	Small Employer Health Benefits Program: relief from obligations	25 N.J.R. 4577(a)	R.1993 d.629	25 N.J.R. 5692(a)
11:21-16	Small Employer Health Benefits Program: withdrawal of carriers from plans market	25 N.J.R. 4859(a)	R.1994 d.26	26 N.J.R. 247(a)

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11:21–App. Exh. E	Small Employer Health Benefits Program: correction to proposed Appendix Exhibit E and extension of comment period	25 N.J.R. 4458(a)		
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12:7	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA): extension of comment period	25 N.J.R. 2216(a)		
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12:23-3	Workforce Development Partnership Program: application and review process for individual training grants	25 N.J.R. 884(a)		
12:23-4	Workforce Development Partnership Program: application and review process for approved training	25 N.J.R. 886(a)		
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12:23-6	Workforce Development Partnership Program: application and review process for employment and training grants for services to disadvantaged workers	25 N.J.R. 1054(a)		
12:41	Job Training Partnership Act: grievance, hearing, and review procedures	25 N.J.R. 5456(a)		
12:45	Vocational Rehabilitation Services: waiver of sunset provision of Executive Order No. 66(1978)	25 N.J.R. 2216(b)		
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12:56-6.1, 7.5, 7.6	Wage and Hour compliance: limousine operators	26 N.J.R. 94(a)		
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12A:10-1	Goods and services contracts for small businesses, minority businesses, and female businesses	25 N.J.R. 4889(a)		
12A:10-2	Minority and female contractor and subcontractor participation in State construction contracts	25 N..R. 4461(b)		
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12A:11-1.2, 1.3, 1.4, 1.7	Certification of women-owned and minority-owned businesses	25 N.J.R. 2484(a)		
12A:31-1.4	Development Authority for Small Businesses, Minorities' and Women's Enterprises: allocation of direct loan assistance	25 N.J.R. 5759(a)		
12A:121	Urban Enterprise Zone Authority: policies	25 N.J.R. 4582(a)	R.1993 d.645	25 N.J.R. 5933(b)
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13:20-43	Enhanced motor vehicle inspection and maintenance program: pre-proposal	25 N.J.R. 3418(a)		
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13:30-1.1	Board of Dentistry: qualifications of applicants for licensure to practice	25 N.J.R. 2216(d)		
13:30-8.6	Board of Dentistry: professional advertising	25 N.J.R. 2823(a)	R.1993 d.651	25 N.J.R. 5934(a)
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13:33-1.35, 1.36	Ophthalmic dispensers and technicians: referrals; space rental agreements	24 N.J.R. 4010(a)	R.1993 d.603	25 N.J.R. 5484(b)
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13:35-6.10	Board of Medical Examiners: request for comment regarding advertising of specialty certification	25 N.J.R. 2824(a)		
13:35-6.17	Board of Medical Examiners: professional fees and investments	25 N.J.R. 5441(a)		
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13:35-11	Board of Medical Examiners: Alternative Resolution Program	25 N.J.R. 2824(b)		
13:37	Board of Nursing rules	25 N.J.R. 455(b)		
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13:37-12.1, 14	Board of Nursing: certification of homemaker-home health aides	25 N.J.R. 1950(a)		
13:37-14	Homemaker-home health aide competency evaluation: public hearing	25 N.J.R. 3704(b)		
13:39-5.2	Board of Pharmacy: information on prescription labels	25 N.J.R. 1667(a)		
13:39A-1.4	Board of Physical Therapy: fees and charges	25 N.J.R. 5446(a)		
13:39A-2.5	Board of Physical Therapy: referral of patients from chiropractors	25 N.J.R. 3938(a)	R.1993 d.642	25 N.J.R. 5488(a)
13:39A-5.2, 5.4, 5.6	Board of Physical Therapy: examination standards for therapists and assistants	25 N.J.R. 5447(a)		
13:40-5.1	Board of Professional Engineers and Land Surveyors: subdivision plats	25 N.J.R. 5447(b)		
13:40A-3.5, 6.1	Board of Real Estate Appraisers: fees; temporary licenses	25 N.J.R. 4863(a)		
13:42-1.2	Board of Psychological Examiners: written examination fee	25 N.J.R. 3929(a)	R.1994 d.22	26 N.J.R. 249(a)
13:42-1.2, 1.3	Board of Psychological Examiners rules	25 N.J.R. 4937(a)		
13:44-1.2, 1.3, 1.4, 2.9	Board of Veterinary Medical Examiners: examinations	25 N.J.R. 3930(a)	R.1993 d.683	25 N.J.R. 5938(a)
13:44C-2.2	Audiology and Speech-Language Pathology Advisory Committee: fees and charges	25 N.J.R. 5448(a)		
13:44D-2.4	Advisory Board of Public Movers and Warehousemen: late renewal and reinstatement fee timeframes	25 N.J.R. 3931(a)	R.1993 d.643	25 N.J.R. 5489(a)
13:44D-4.1, 4.2	Advisory Board of Public Movers and Warehousemen: bill of lading and insurance legal liability	25 N.J.R. 5449(a)		
13:44E-1.1	Board of Chiropractic Examiners: scope of chiropractic practice	25 N.J.R. 3931(b)		
13:44E-2.1	Board of Chiropractic Examiners: licensee advertising	25 N.J.R. 3932(a)		
13:44E-2.6	Board of Chiropractic Examiners: practice identification educational requirements	25 N.J.R. 3934(a)		
13:44E-2.8	Board of Chiropractic Examiners: duties of unlicensed assistants	25 N.J.R. 3935(a)		
13:44E-2.9	Board of Chiropractic Examiners: notification of change of address; service of process	25 N.J.R. 3936(a)		
13:44E-2.10, 2.11	Board of Chiropractic Examiners: display of license; right to licensure hearing	25 N.J.R. 3936(b)		
13:44E-2.13	Board of Chiropractic Examiners: overutilization of services; excessive fees	25 N.J.R. 3937(a)		
13:44E-2.14	Board of Chiropractic Examiners: referral of patients to physical therapists	25 N.J.R. 3938(a)	R.1993 d.642	25 N.J.R. 5488(a)
13:44G-1–5, 7, 8	Board of Social Work Examiners rules	25 N.J.R. 3081(a)		
13:45A-21, 22	Kosher Enforcement Bureau: sale of food represented as kosher	25 N.J.R. 3086(a)		
13:45A-26	Automotive dispute resolution	25 N.J.R. 3939(a)		
13:46-2	Athletic Control Board: participant health and safety in boxing and combative sports events	25 N.J.R. 4717(a)		
13:47B	Weights and measures	25 N.J.R. 5102(a)		
13:49	State Medical Examiner: standards for procedures and investigations	25 N.J.R. 5104(a)	R.1994 d.30	26 N.J.R. 484(a)
13:70-1.31	Thoroughbred racing: prohibited services by Racing Commission employees and appointees	25 N.J.R. 4458(b)	R.1993 d.684	25 N.J.R. 5938(b)
13:70-12.4	Thoroughbred racing: claimed horse	25 N.J.R. 1059(a)		

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13:70-14A.9	Thoroughbred racing: administering medication to respiratory bleeders	25 N.J.R. 3100(a)		
13:70-19.44	Thoroughbred racing: conflicts of interest involving veterinary practitioner and spouse	25 N.J.R. 5107(a)		
13:70-20.11	Thoroughbred racing: limitations on entering or starting	25 N.J.R. 3101(a)		
13:70-20.13	Thoroughbred racing: trainer fees	25 N.J.R. 5107(b)		
13:70-21.4	Thoroughbred racing: medication	25 N.J.R. 3102(a)		
13:70-29.52	Thoroughbred racing: Pick(N)	25 N.J.R. 4585(b)	R.1993 d.685	25 N.J.R. 5938(c)
13:70-29.61	Thoroughbred racing: Superfecta	25 N.J.R. 5450(a)		
13:71-1.26	Harness racing: prohibited services by Racing Commission employees and appointees	25 N.J.R. 4459(a)	R.1993 d.686	25 N.J.R. 5939(a)
13:71-9.5	Harness racing: conflicts of interest involving veterinary practitioner and spouse	25 N.J.R. 5108(a)		
13:71-23.1	Harness racing: intent of medication rules	25 N.J.R. 3104(a)		
13:71-23.8	Harness racing: administering medication to respiratory bleeders	25 N.J.R. 3105(a)		
13:71-27.54	Harness racing: Daily Triple	25 N.J.R. 5109(a)		
13:71-27.59	Harness racing: Superfecta	25 N.J.R. 5451(a)		
13:71-29	Harness racing: sulky	26 N.J.R. 95(a)		
13:72-1.1, 2.9, 4.3, 4.10, 6.2, 7.1, 8.1	Casino simulcasting of horse races	25 N.J.R. 5110(a)		
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14:0	Intrastate dial-around compensation: preproposal	25 N.J.R. 4586(a)		
14:3-3.6	Discontinuance of service to multi-family dwellings	25 N.J.R. 1346(a)		
14:12-2.1	Filing of Demand Side Management Resource Plans	25 N.J.R. 5111(a)		
14:17	Office of Cable Television: practice and procedure	26 N.J.R. 96(a)		
14:18-2.11	Cable television: pre-proposal regarding disposition of on-premises wiring	24 N.J.R. 4496(a)		
14:18-2.11	Cable television: change in hearing date and comment period for pre-proposal regarding disposition of on-premises wiring	25 N.J.R. 270(a)		
14:18-3.24	Cable television: late fees and charges	26 N.J.R. 105(a)		
14:18-10.5	Cable television: performance monitoring	25 N.J.R. 2700(a)		
14:18-10.5	Cable television: monitor point tests	26 N.J.R. 104(a)		

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14A:14	Certification of need for electric facilities	25 N.J.R. 5745(a)		

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15:1	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1347(a)	R.1993 d.621	25 N.J.R. 5489(a)
15:10-8	Certification of electronic voting systems	25 N.J.R. 4587(a)		
15:10-8	Certification of electronic voting systems: public hearing and extension of comment period	25 N.J.R. 4864(a)		

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16:1B	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1478(a)	R.1993 d.622	25 N.J.R. 5491(a)
16:28-1.32, 1.56	Speed limit zones along Route 154 in Cherry Hill, and U.S. 40 and U.S. 40/322 in Egg Harbor and Pleasantville	26 N.J.R. 106(a)		
16:28A-1.9, 1.18, 1.19, 1.37	Parking restrictions along Route 17 in Paramus, Route 27 in Rahway, Route 28 in Bound Brook, and Route 70 in Manchester	25 N.J.R. 4725(a)	R.1994 d.1	26 N.J.R. 250(a)
16:28A-1.19	Time limit parking zone along Route 28 in Somerville	25 N.J.R. 5111(b)		
16:28A-1.19, 1.57	Parking restrictions along Route 28 in Bound Brook and U.S. 206 in Hamilton Township	25 N.J.R. 4459(b)	R.1993 d.623	25 N.J.R. 5493(a)
16:28A-1.34, 1.71	Restricted parking along Route 49 in Millville and Route 67 in Fort Lee	25 N.J.R. 5760(a)		
16:28A-1.38	No stopping or standing zones along Route 71 in Spring Lake Heights	25 N.J.R. 5112(a)		

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16:28A-1.41	Time limit parking on Route 77 in Bridgeton: correction to proposal	25 N.J.R. 3944(a)		
16:30-3.9	HOV lane on Route I-80 in Morris County	25 N.J.R. 5761(a)		
16:30-3.10	Lane usage along I-287 in Morris County	26 N.J.R. 107(a)		
16:30-10.16	Midblock crosswalks along Route 71 in West Long Branch and Eatontown	25 N.J.R. 5762(a)		
16:31-1.32	U turn prohibition along Route 36 in Sea Bright	25 N.J.R. 4460(b)	R.1993 d.624	25 N.J.R. 5493(b)
16:31-1.33	U turn prohibition along Route 12 in Flemington and Raritan Township	25 N.J.R. 4460(a)	R.1993 d.625	25 N.J.R. 5493(c)
16:41C-1.1, 8.7	Roadside sign control and outdoor advertising along Atlantic City Expressway	Emergency (expires 1-16-93)	R.1993 d.652	25 N.J.R. 5699(a)
16:41D	Motorist service signs on non-urban interstate and limited access highways	25 N.J.R. 2836(a)		
16:44	Construction services	25 N.J.R. 1954(a)		
16:44	Construction Services: waiver of sunset provision of Executive Order No. 66(1978)	25 N.J.R. 2227(a)		
16:44	Construction services	25 N.J.R. 4727(a)		
16:47-8.5	State Highway Access Management Code: access classifications	25 N.J.R. 3945(a)	R.1993 d.601	25 N.J.R. 5494(a)
16:50	Employer Trip Reduction Program (ETRP)	25 N.J.R. 3132(a)	R.1993 d.626	25 N.J.R. 5494(b)
16:50-8.9, 11	Employer Trip Reduction Program: employee transportation coordinator training; disclosure of information	25 N.J.R. 5452(a)		

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17:2-4.3	Public Employees' Retirement System: school year members	26 N.J.R. 108(a)		
17:3	Teachers' Pension and Annuity Fund	25 N.J.R. 4461(a)	R.1993 d.658	25 N.J.R. 5942(a)
17:3-1.1	Teachers' Pension and Annuity Fund: conduct of Board meetings	25 N.J.R. 5762(b)		
17:3-4.3	Teachers' Pension and Annuity Fund: school year members	26 N.J.R. 108(b)		
17:6	Consolidated Police and Firemen's Pension Fund	25 N.J.R. 3946(a)	R.1993 d.659	25 N.J.R. 5942(b)
17:9-4.1, 4.5	State Health Benefits Program: appointive officer eligibility	26 N.J.R. 109(a)		
17:13	Goods and services contracts for small businesses, minority businesses, and female businesses	25 N.J.R. 4889(a)		
17:14	Minority and female contractor and subcontractor participation in State construction contracts	25 N.J.R. 4461(b)		

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18:12-4.5	Local property tax assessors: conflict of interest	25 N.J.R. 4591(a)		
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18:12A-1.18	Local property tax assessors: conflict of interest	25 N.J.R. 4591(a)		
18:23	Railroad Property Tax	26 N.J.R. 110(a)		
18:35-1.14, 1.25	Gross Income Tax: partnerships; net profits from business	25 N.J.R. 677(a)		
18:35-1.17	Gross income tax: Health Care Subsidy Fund withholding	25 N.J.R. 1957(a)		
18:35-1.27	Gross Income Tax: interest on overpayments	26 N.J.R. 112(a)		
18:35-2.2	Gross Income Tax: setoff of individual liability	25 N.J.R. 5454(a)		

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19:4A-3.1, 4.4, 5.3, 5.7, 6.2	HMDC: District zoning rules	25 N.J.R. 3949(a)	R.1994 d.16	26 N.J.R. 252(a)
19:30-7	Economic Development Authority: Disability discrimination complaint procedure	25 N.J.R. 4864(b)		
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19:40-1.2	Casino operation certificate	25 N.J.R. 5893(a)		
19:40-1.2, 3.3	Definitions	25 N.J.R. 4866(a)	R.1994 d.31	26 N.J.R. 486(a)
19:40-4.1, 4.2, 4.8	Confidential information	25 N.J.R. 5891(a)		
19:40-6	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1503(a)	R.1993 d.613	25 N.J.R. 5519(a)
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19:41-1.4	Casino operation certificate	25 N.J.R. 5893(a)		
19:41-1.7	Work permits	25 N.J.R. 5114(b)		
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19:42-1.1	Definitions	25 N.J.R. 4866(a)	R.1994 d.31	26 N.J.R. 486(a)
19:42-4.5	Exclusion of persons from casino premises	25 N.J.R. 4739(a)	R.1994 d.32	26 N.J.R. 487(a)
19:42-5.3	Hearings: multiple party representation	25 N.J.R. 5115(a)		
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19:43-9.2	Casino licensee employment requirements: persons denied licensure or with revoked or suspended licensure or registration	25 N.J.R. 4871(a)		
19:43-9.3	Casino employee reporting and recordkeeping requirements; experiential hours	25 N.J.R. 5114(b)		
19:43-13.1	Definitions	25 N.J.R. 4866(a)	R.1994 d.31	26 N.J.R. 486(a)
19:44-8.3	Poker	25 N.J.R. 5906(a)		
19:45-1.1	Definitions	25 N.J.R. 4866(a)	R.1994 d.31	26 N.J.R. 486(a)
19:45-1.1, 1.1A, 1.2, 1.8, 1.10, 1.11, 1.12, 1.15, 1.19, 1.33, 1.46–1.51	Keno	26 N.J.R. 115(a)		
19:45-1.1, 1.2, 1.11, 1.12, 1.20	Poker	25 N.J.R. 5906(a)		
19:45-1.1, 1.8, 1.16, 1.18, 1.46	Match play coupons	25 N.J.R. 5902(a)		
19:45-1.1, 1.14A	Casino simulcasting	25 N.J.R. 4737(a)	R.1994 d.33	26 N.J.R. 489(a)
19:45-1.1, 1.16, 1.33, 1.36, 1.37, 1.42, 1.44, 1.46, 1.46A, 1.46B	Coupon redemption for slot machine play	25 N.J.R. 4471(a)		
19:45-1.3, 1.10, 1.11, 1.14, 1.32, 1.34	Casino operation certificate	25 N.J.R. 5893(a)		
19:45-1.8	Records retention	25 N.J.R. 5905(a)		
19:45-1.9, 1.9B	Direct mass marketing complimentary programs	25 N.J.R. 4871(b)	R.1994 d.34	26 N.J.R. 491(a)
19:45-1.9, 1.9B	Complimentary services or items; cash and noncash gifts	26 N.J.R. 113(a)		
19:45-1.11A	Jobs compendium submission	26 N.J.R. 114(a)		
19:45-1.12A	Minimum and maximum gaming wagers	25 N.J.R. 3953(a)	R.1993 d.630	25 N.J.R. 5521(a)
19:45-1.19	Card-o-lette	25 N.J.R. 2230(a)		
19:45-1.29	Approval of listings of uncollectible checks	25 N.J.R. 5114(a)		
19:45-1.41	Slot machine hopper fills	25 N.J.R. 4474(a)	R.1993 d.631	25 N.J.R. 5522(a)
19:45-1.42	Unsecured currency in a bill changer	25 N.J.R. 4873(a)		
19:45-1.46	Coupon redemption programs: administrative correction	————	————	25 N.J.R. 5943(c)
19:46-1.1, 1.4, 1.5	Gaming chips	25 N.J.R. 3111(a)		
19:46-1.1, 1.8, 1.9, 1.13F, 1.20	Card-o-lette	25 N.J.R. 2230(a)		
19:46-1.4, 1.5	Match play coupons	25 N.J.R. 5902(a)		
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19:46-1.10, 1.16, 1.19, 1.20	Casino operation certificate	25 N.J.R. 5893(a)		
19:46-1.12	Minibaccarat: charging vigorish	25 N.J.R. 4474(b)	R.1993 d.655	25 N.J.R. 5944(a)
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19:46-1.19	Dealing shoes: administrative correction	————	————	26 N.J.R. 492(a)
19:46-1.20	Casino simulcasting	25 N.J.R. 4737(a)	R.1994 d.33	26 N.J.R. 489(a)
19:46-1.26	Coupon redemption for slot machine play	25 N.J.R. 4471(a)		
19:47	Poker: temporary adoption of new rules	25 N.J.R. 2001(a)		
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19:47-2.2, 2.17	Additional wagers in blackjack	25 N.J.R. 5454(b)		
19:47-2.3, 2.17, 3.2, 6.5, 7.2, 10.5, 11.7	Match play coupons	25 N.J.R. 5902(a)		
19:47-2.5, 2.6, 5.2, 8.5	Casino operation certificate	25 N.J.R. 5893(a)		
19:47-7.2, 7.3	Minibaccarat: charging vigorish	25 N.J.R. 4474(b)	R.1993 d.655	25 N.J.R. 5944(a)
19:47-8.2, 15	Card-o-lette	25 N.J.R. 2230(a)		
19:47-14	Poker	25 N.J.R. 5906(a)		
19:47-16	Keno	26 N.J.R. 115(a)		
19:48-1.1, 1.3, 1.4, 1.5, 1.7, 1.8	Exclusion of persons from casino premises	25 N.J.R. 4739(a)	R.1994 d.32	26 N.J.R. 487(a)
19:50	Casino hotel alcoholic beverage control	25 N.J.R. 4742(a)	R.1994 d.29	26 N.J.R. 492(b)
19:51-1.1	Definitions	25 N.J.R. 4866(a)	R.1994 d.31	26 N.J.R. 486(a)
19:51-1.1	Match play coupons	25 N.J.R. 5902(a)		
19:51-1.2	Casino simulcasting	25 N.J.R. 4737(a)	R.1994 d.33	26 N.J.R. 489(a)
19:54-1.2	Definitions	25 N.J.R. 4866(a)	R.1994 d.31	26 N.J.R. 486(a)
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19:55-1.1, 2.9, 4.3, 4.10, 6.2, 7.1, 8.1	Casino simulcasting	25 N.J.R. 4737(a)	R.1994 d.33	26 N.J.R. 489(a)
19:65-1.2, 2.2, 2.4–2.11, 6.1, 6.2	Hotel development and corridor region projects	25 N.J.R. 4476(a)		
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