

CHAPTER 4

ACTUARIAL SERVICES

Authority

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

Source and Effective Date

R.1996 d.4, effective November 30, 1995.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Executive Order No. 66(1978) Expiration Date

Chapter 4, Actuarial Services, expires on November 30, 2000.

Chapter Historical Note

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

1972 Revisions: Subchapter 2, Replacement of Life Insurance Policy, was originally filed and became effective April 1, 1972 as R.1972 d.21.

1973 Revisions: Subchapter 7, Procedure for the Regulation of Consent to Higher Rate Filings, was filed March 23, 1973 as R.1973 d.82, effective April 15, 1973, for automobile insurance; and effective July 1, 1973, for all other lines of insurance. See: 4 N.J.R. 220(a), 5 N.J.R. 113(b).

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

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

1977 Revisions: Subchapter 13, Group Student Health Insurance, was adopted as new rules by R.1977 d.309, effective August 22, 1977. See: 9 N.J.R. 343(c), 9 N.J.R. 438(d). Subchapter 14, Home Health Care Insurance Coverage, was adopted as new rules by R.1977 d.476, effective December 15, 1977. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

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

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

1980 Revisions: Subchapter 16, Minimum Standards for Individual Health Insurance; Subchapter 17, Health Insurance Solicitation; and Subchapter 18, Individual Health Insurance Rate Filings, were adopted as new rules by R.1980 d.176, effective April 21, 1980. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c). On June 12, 1980, the New Jersey Legislature adopted Senate Concurrent Resolution 110 disapproving Subchapters 16, 17 and 18 pursuant to N.J.S.A. 17B:26-45d. On August 5, 1980, the Department of Insurance readopted Subchapters 16, 17 and 18 in their entirety, with amendments to N.J.A.C. 11:4-16.8(b), 11:4-17.6 and 11:4-17.7, as R.1980 d.343. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b). Subchapter 21, Limited Death Benefits Forms, was adopted as new rules by R.1980 d.265, effective June 18, 1980. See: 12 N.J.R. 279(b), 12 N.J.R. 423(c).

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

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

1984 Revisions: Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables, was adopted as new rules by R.1984 d.478, effective November 5, 1984. See: 16 N.J.R. 1452(a), 16 N.J.R. 3040(a). Pursuant to Executive Order No. 66(1978), Subchapter 6, Reserve Standards for Individual Health Insurance Policies, was readopted as R.1984 d.512, effective November 5, 1984. See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

1985 Revisions: Subchapter 23, Medicare Supplement Policies and Contracts, was adopted as new rules by R.1985 d.70, effective February 19, 1985 (operative June 19, 1985). See: 16 N.J.R. 2945(a), 17 N.J.R. 460(a). Pursuant to Executive Order No. 66(1978), Subchapter 20 was readopted as R.1985 d.161, effective April 1, 1985. See: 17 N.J.R. 168(a), 17 N.J.R. 820(a). Pursuant to Executive Order No. 66(1978), Subchapters 16, 17 and 18 were readopted as R.1985 d.221, effective April 15, 1985. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a). Subchapter 21 was readopted as R.1985 d.325, effective June 3, 1985. See: 17 N.J.R. 891(a), 17 N.J.R. 1660(a). Subchapter 24, Smoker and Non-smoker Mortality Tables, was adopted as new rules by R.1985 d.617, effective December 2, 1985. See: 17 N.J.R. 2348(a), 17 N.J.R. 2907(a). Subchapter 26, Annuity Mortality Tables, was adopted as new rules by R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 290(a).

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

1988 Revisions: Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, was adopted as new rules by R.1988 d.455, effective September 19, 1988. See: 20 N.J.R. 43(a), 20 N.J.R. 2377(c). Subchapter 28, Group Coordination of Benefits, was adopted as new rules by R.1988 d.499, effective October 17, 1988. See: 20 N.J.R. 1773(b), 20 N.J.R. 2581(a).

1989 Revisions: Subchapter 29, Homeowners Comparison Survey, was adopted as new rules by R.1989 d.50, effective January 17, 1989. See: 20 N.J.R. 2181(a), 21 N.J.R. 164(a). Subchapter 31, Term Life Insurance Comparison Survey, was adopted as new rules by R.1989 d.122, effective February 21, 1989. See: 20 N.J.R. 2990(a), 21 N.J.R. 566(a). Subchapter 32, Health Service Corporation Notice of Increased Rates, was adopted as R.1989 d.522, effective October 2, 1989. See: 21 N.J.R. 973(b), 21 N.J.R. 3173(c). Subchapter 33, Excess Interest Reserve Adjustment, was adopted as new rules by R.1989 d.523, effective October 2, 1989. See: 21 N.J.R. 1308(a), 21 N.J.R. 3175(c). Subchapter 34, Long-Term Care Insurance, was adopted as new rules by R.1989 d.571, effective November 6, 1989. See: 21 N.J.R. 1964(a), 21 N.J.R. 3465(a).

1990 Revisions: Subchapter 25 regarding Medicare supplement interim standards, was adopted as new rules by R.1990 d.214, effective April 16, 1990. See: 22 N.J.R. 320(a), 22 N.J.R. 1266(b).

1991 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1991 d.3, effective November 30, 1990. As part of R.1991 d.3, Subchapter 1, Contracts on a Variable Basis, was repealed effective January 7, 1991. See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a). Subchapter 35, Annual Medicare Supplement Policy Survey, was adopted as new rules by R.1991 d.122, effective March 4, 1991. See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a). Subchapter 23, Medicare Supplement Policies and Contracts, was changed to Minimum Standards for Medicare Supplement Coverage by R.1991 d.345, effective July 1, 1991. See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a). Notice of Action on Petition for Rulemaking: Regulation of Authority on Group Health Insurance Contracts. See: 23 N.J.R. 2546(c). Denial of Petition for Rulemaking: Declaration of Authority to Regulate Group Health Insurance Contracts. See: 23 N.J.R. 3827(a).

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

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

1995 Revisions: Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures, was adopted as new rules by R.1995 d.406, effective August 7, 1995. See: 27 N.J.R. 1356(b), 27 N.J.R. 2931(a). Subchapter 30, Accelerated Death Benefits, was adopted as new rules by R.1995 d.521, effective September 18, 1995. See: 27 N.J.R. 2046(a), 27 N.J.R. 3613(c). Subchapter 40, Life/Health/Annuity Forms, was adopted as new rules by R.1995 d.569, effective November 6, 1995. See: 27 N.J.R. 2857(a), 27 N.J.R. 2867(a), 27 N.J.R. 4317(a). An administrative correction, published November 20, 1995, restored comments to the notice of adoption of Subchapter 40 which were inadvertently omitted. See: 27 N.J.R. 4728(a).

1996 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1996 d.4, effective November 30, 1995. As part of R.1996 d.4, Subchapter 5, Amendment to Instructions to Life and Accident and Health Annual Statement Blank; Subchapter 10, Expense Experience; Subchapter 32, Health Service Corporation Notice of Increased Rates; Subchapter 35, Annual Medicare Supplement Policy Survey; and Exhibits A and B of the Appendix to Subchapters 16 and 23 were repealed effective January 2, 1996. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. (RESERVED)

SUBCHAPTER 2. REPLACEMENT OF LIFE INSURANCE POLICY

11:4-2.1 Purpose

(a) The purpose of this subchapter is:

1. To regulate the activities of insurers and agents with respect to the replacement of existing life insurance;
2. To protect the interests of life insurance policyowners by establishing minimum standards of conduct to be

observed in the replacement or proposed replacement of existing life insurance by:

- i. Assuring that the policyowner receives information with which a decision can be made in his or her own best interest;
- ii. Reducing the opportunity for misrepresentation and incomplete disclosures; and
- iii. Establishing penalties for failure to comply with the requirements of this subchapter.

11:4-2.2 Definitions

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

“Conservation” means any attempt by the existing insurer or its agent to continue existing life insurance in force when existing insurer has received a Comparative Information Form as required by N.J.A.C. 11:4-2.5(a)3iv from a replacing insurer. A conservation effort does not include routine administrative procedures like late payment reminders, late payment offers or reinstatement offers.

“Direct-response sales” means any sale of life insurance where the insurer does not utilize an agent in the sale or delivery of the policy.

“Existing insurer” means the insurance company whose policy is or will be changed or terminated in such a manner as described within the definition of “replacement”.

“Existing life insurance” means any life insurance in force including life insurance under a binding or conditional receipt or a life insurance policy that is within an unconditional refund period, but excluding life insurance obtained through the exercise of a dividend option.

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

“Replacement” means any transaction in which new life insurance is to be purchased, and it is known or should be known to the proposing agent, or to the proposing insurer if there is no agent, that by reason of such transaction, existing life insurance has been or is to be:

1. Lapsed, forfeited, surrendered, or otherwise terminated;
2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
4. Reissued with any reduction in cash value; or

5. Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding 25 percent of the loan value set forth in the policy.

“Replacing insurer” means the insurance company that issues a new policy which is a replacement of existing life insurance.

“Sales Proposal” means individualized, written sales aids of all kinds, excluding Comparative Information Forms and Policy Summaries, which are used by an insurer, agent or broker in comparing existing life insurance to proposed life insurance in order to recommend the replacement or conservation of existing life insurance. Sales aids of a generally descriptive nature, which are maintained in the insurer’s advertising compliance file, shall not be considered a Sales Proposal within the meaning of this definition.

11:4-2.3 Exemptions

(a) Unless otherwise specifically included, this subchapter shall not apply to:

1. Annuities;
2. Individual credit life insurance;
3. Group life insurance, group credit life insurance, and life insurance policies issued in connection with a pension, profit-sharing or other benefit plan qualifying for tax deductibility of premiums, provided, however, that as to any plan described in this subsection, full and complete disclosure of all material facts shall be given to the administrator of any plan to be replaced;
4. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account;
5. An application to the existing insurer that issued the existing life insurance and a contractual change or conversion privilege is being exercised;
6. Existing life insurance that is a non-convertible term life insurance policy which will expire in five years or less and cannot be renewed; or
7. Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company.

11:4-2.4 Duties of agent

(a) Each agent shall submit to the replacing insurer with or as part of each application for life insurance:

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

7. 0 percent Male 100 percent Female for tables to be designated as the "1980 CSO-G" and "1980 CET-G" tables.

(c) The table described in (b)7 above is not to be used with respect to policies issued on or after January 1, 1986, except where the proportion of persons insured is anticipated to be 90 percent or more female.

(d) Gender blended tables with Ten-Year Select Mortality Factors may be derived by applying select factors to gender blended tables without select factors where the select factors are derived by using the following formula:

$${}^Z F_t^T = \frac{(Z)F_t^M + .6(1-Z)F_t^F}{Z + .6(1-Z)}$$

where

${}^Z F_t^T$ is the gender blended select factor for year t

F_t^M is the male select factor for year t

F_t^F is the female select factor for year t

Z is the ratio of male lives to the total lives at the pivotal age

Amended by R.1996 d.4, effective January 2, 1996.

See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Amended by R.1996 d.148, effective March 18, 1996.

See: 27 N.J.R. 3717(a), 28 N.J.R. 1545(a).

11:4-22.4 Construction of Gender Blended Smoker and Nonsmoker Mortality Tables for use in the determination of minimum nonforfeiture benefits and minimum reserves

(a) In determining minimum cash surrender values, and amounts of paid up nonforfeiture benefits for any policy of insurance on the life of either a male or female insured on a form of insurance with separate rates for smokers and nonsmokers delivered or issued for delivery in this State after the operative date of N.J.S.A. 17B:25-19h(xi) for that policy form in addition to the mortality tables that may be used according to N.J.A.C. 11:4-22.3:

1. A mortality table which is a blend of the male and female rates of mortality according to the 1980 CSO Smoker Mortality Table, in the case of lives classified as smokers, or the 1980 CSO Nonsmoker Mortality Table, in the case of lives classified as nonsmokers, with or without Ten-year Select Mortality Factors, may at the option of the company be substituted for the 1980 CSO Table, with or without Ten-Year Select Mortality Factors; and

2. A mortality table which is of the same blend as used in (a)1 above but applied to form a blend of the male and female rates of mortality according to the corresponding 1980 CET Smoker Mortality Table or 1980 CET Nonsmoker Mortality Table may at the option of the company be substituted for the 1980 CET Table.

(b) The following describes the blended Smoker and Nonsmoker Mortality Tables. The tables are contained in Appendix B to this subchapter.

1. 100 percent Male 0 percent Female smoker tables designated as "1980 CSO-SA" and "1980 CET-SA" Tables.

2. 80 percent Male 20 percent Female smoker tables designated as "1980 CSO-SB" and "1980 CET-SB" Tables.

3. 60 percent Male 40 percent Female smoker tables designated as "1980 CSO-SC" and "1980 CET-SC" Tables.

4. 50 percent Male 50 percent Female smoker tables designated as "1980 CSO-SD" and "1980 CET-SD" Tables.

5. 40 percent Male 60 percent Female smoker tables designated as "1980 CSO-SE" and "1980 CET-SE" Tables.

6. 20 percent Male 80 percent Female smoker tables designated as "1980 CSO-SF" and "1980 CET-SF" Tables.

7. 0 percent Male 100 percent Female smoker tables designated as "1980 CSO-SG" and "1980 CET-SG" Tables.

8. 100 percent Male 0 percent Female nonsmoker tables designated as "1980 CSO-NA" and "1980 CET-NA" Tables.

9. 80 percent Male 20 percent Female nonsmoker tables designated as "1980 CSO-NB" and "1980 CET-NB" Tables.

10. 60 percent Male 40 percent Female nonsmoker tables designated as "1980 CSO-NC" and "1980 CET-NC" Tables.

11. 50 percent Male 50 percent Female nonsmoker tables designated as "1980 CSO-ND" and "1980 CET-ND" Tables.

12. 40 percent Male 60 percent Female nonsmoker tables designated as "1980 CSO-NE" and "1980 CET-NE" Tables.

13. 20 percent Male 80 percent Female nonsmoker tables designated as "1980 CSO-NF" and "1980 CET-NF" Tables.

14. 0 percent Male 100 percent Female nonsmoker tables designated as "1980 CSO-NG" and "1980 CET-NG" Tables.

(c) The tables described in (b)7 and 14 above are not acceptable as blended tables, except where the proportion of persons insured is anticipated to be 90 percent or more female.

Amended by R.1996 d.148, effective March 18, 1996.

See: 27 N.J.R. 3717(a), 28 N.J.R. 1545(a).

11:4-22.5 Use of gender blended mortality tables in the non-Norris market

(a) The preceding rules in this subchapter are intended to address use of gender blended mortality tables as a minimum standard for cash surrender values and paid-up non-forfeiture benefits in the *Norris* market.

(b) The use of gender blended mortality tables as the basis for cash surrender values and paid-up nonforfeiture benefits in the non-*Norris* market will be permitted only upon receipt of an actuarial demonstration that the resultant cash values are at least equal to the statutory minimum using the maximum interest rate, maximum initial expense allowance and gender district table specified at N.J.S.A. 17B:25-19.

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

11:4-22.6 Effect on previously filed forms

Forms which have been filed by the Commissioner pursuant to N.J.S.A. 17B:25-18 containing provisions not in compliance with these rules shall be deemed withdrawn as of September 18, 1996.

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

11:4-22.7 Unfair discrimination

It shall not be a violation of N.J.S.A. 17B:30-12c. for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

Recodified: This section was 11:4-22.4.
See: 19 N.J.R. 1399(a), 19 N.J.R. 1814(a).
Recodified from 11:4-22.5 and amended by R.1996 d.148, effective March 18, 1996.
See: 27 N.J.R. 3717(a), 28 N.J.R. 1545(a).

11:4-22.8 Separability

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

Recodified: This section was 11:4-22.5.
See: 19 N.J.R. 1399(a), 19 N.J.R. 1814(a).
Recodified from 11:4-22.6 and amended by R.1996 d.148, effective March 18, 1996.
See: 27 N.J.R. 3717(a), 28 N.J.R. 1545(a).

Age (x)	1980 CSO-A	1980 CET-A
1	1.07	1.82
2	0.99	1.74
3	0.98	1.73
4	0.95	1.70
5	0.90	1.65
6	0.86	1.61
7	0.80	1.55
8	0.76	1.51
9	0.74	1.49
10	0.73	1.48
11	0.77	1.52
12	0.85	1.60
13	0.99	1.74
14	1.15	1.90
15	1.33	2.08
16	1.51	2.26
17	1.67	2.42
18	1.78	2.53
19	1.86	2.61
20	1.90	2.65
21	1.91	2.66
22	1.89	2.64
23	1.86	2.61
24	1.82	2.57
25	1.77	2.52
26	1.73	2.48
27	1.71	2.46
28	1.70	2.45
29	1.71	2.46
30	1.73	2.48
31	1.78	2.53
32	1.83	2.58
33	1.91	2.66
34	2.00	2.75
35	2.11	2.86
36	2.24	2.99
37	2.40	3.15
38	2.58	3.35
39	2.79	3.63
40	3.02	3.93
41	3.29	4.28
42	3.56	4.63
43	3.87	5.03
44	4.19	5.45
45	4.55	5.92
46	4.92	6.40
47	5.32	6.92
48	5.74	7.46
49	6.21	8.07
50	6.71	8.72
51	7.30	9.49
52	7.96	10.35
53	8.71	11.32
54	9.56	12.43
55	10.47	13.61

APPENDIX A

TABLE 1
1980 CSO-A AND 1980 CET-A MORTALITY TABLES
BASED ON BLENDING 1980 CSO AND 1980 CET
MORTALITY TABLES 100 PERCENT MALE—
PERCENT FEMALE
RATES OF MORTALITY
1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO-A	1980 CET-A
0	4.18	5.43

Age (x)	1980 CSO-A	1980 CET-A	Age (x)	1980 CSO-B	1980 CET-B
56	11.46	14.90	1	1.04	1.79
57	12.49	16.24	2	.95	1.70
58	13.59	17.67	3	.94	1.69
59	14.77	19.20	4	.91	1.66
60	16.08	20.90	5	.87	1.62
61	17.54	22.80	6	.83	1.58
62	19.19	24.95	7	.79	1.54
63	21.06	27.38	8	.75	1.50
64	23.14	30.08	9	.73	1.48
65	25.42	33.05	10	.72	1.47
66	27.85	36.21	11	.75	1.50
67	30.44	39.57	12	.83	1.58
68	33.19	43.15	13	.94	1.69
69	36.17	47.02	14	1.08	1.83
70	39.51	51.36	15	1.24	1.99
71	43.30	56.29	16	1.39	2.14
72	47.65	61.95	17	1.53	2.28
73	52.64	68.43	18	1.62	2.37
74	58.19	75.65	19	1.69	2.44
75	64.19	83.45	20	1.74	2.49
76	70.53	91.69	21	1.75	2.50
77	77.12	100.26	22	1.73	2.48
78	83.90	109.07	23	1.71	2.46
79	91.05	118.37	24	1.69	2.44
80	98.84	128.49	25	1.65	2.40
81	107.48	139.72	26	1.63	2.38
82	117.25	152.43	27	1.61	2.36
83	128.26	166.74	28	1.61	2.36
84	140.25	182.33	29	1.63	2.38
85	152.95	198.84	30	1.65	2.40
86	166.09	215.92	31	1.70	2.45
87	179.55	233.42	32	1.75	2.50
88	193.27	251.25	33	1.83	2.58
89	207.29	269.48	34	1.91	2.66
90	221.77	288.30	35	2.02	2.77
91	236.98	308.07	36	2.14	2.89
92	253.45	329.49	37	2.30	3.05
93	272.11	353.74	38	2.47	3.22
94	295.90	384.67	39	2.68	3.48
95	329.96	428.95	40	2.90	3.77
96	384.55	499.92	41	3.16	4.11
97	480.20	624.26	42	3.42	4.45
98	657.98	855.37	43	3.72	4.84
99	1000.00	1000.00	44	4.01	5.21

TABLE 2
 1980 CSO-B AND 1980 CET-B MORTALITY TABLES
 BASED ON BLENDING 1980 CSO AND 1980 CET
 MORTALITY TABLES 80 PERCENT MALE—
 20 PERCENT FEMALE
 (PIVOTAL AGE 45)
 RATES OF MORTALITY
 1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO-B	1980 CET-B	Age (x)	1980 CSO-B	1980 CET-B
0	3.92	5.10	45	4.35	5.66
			46	4.70	6.11
			47	5.07	6.59
			48	5.45	7.09
			49	5.89	7.66
			50	6.36	8.27
			51	6.90	8.97
			52	7.50	9.75
			53	8.19	10.65
			54	8.96	11.65
			55	9.78	12.71

Age (x)	1980 CSO-B	1980 CET-B	Age (x)	1980 CSO-C	1980 CET-C
56	10.67	13.87	1	.99	1.74
57	11.58	15.05	2	.93	1.68
58	12.54	16.30	3	.90	1.65
59	13.57	17.64	4	.88	1.63
60	14.72	19.14	5	.84	1.59
61	16.00	20.80	6	.81	1.56
62	17.47	22.71	7	.77	1.52
63	19.16	24.91	8	.73	1.48
64	21.05	27.37	9	.73	1.48
65	23.11	30.04	10	.71	1.46
66	25.29	32.88	11	.74	1.49
67	27.61	35.89	12	.80	1.55
68	30.03	39.04	13	.89	1.64
69	32.66	42.46	14	1.01	1.76
70	35.59	46.27	15	1.14	1.89
71	38.95	50.64	16	1.27	2.02
72	42.84	55.69	17	1.38	2.13
73	47.33	61.53	18	1.47	2.22
74	52.37	68.08	19	1.52	2.27
75	57.84	75.19	20	1.56	2.31
76	63.65	82.75	21	1.58	2.33
77	69.70	90.61	22	1.58	2.33
78	75.95	98.74	23	1.56	2.31
79	82.57	107.34	24	1.55	2.30
80	89.83	116.78	25	1.53	2.28
81	97.94	127.32	26	1.52	2.27
82	107.18	139.33	27	1.51	2.26
83	117.65	152.95	28	1.53	2.28
84	129.10	167.83	29	1.54	2.29
85	141.38	183.79	30	1.58	2.33
86	154.17	200.42	31	1.63	2.38
87	167.49	217.74	32	1.67	2.42
88	181.24	235.61	33	1.75	2.50
89	195.54	254.20	34	1.83	2.58
90	210.53	273.69	35	1.93	2.68
91	226.51	294.46	36	2.04	2.79
92	244.13	317.37	37	2.20	2.95
93	264.04	343.25	38	2.36	3.11
94	289.36	376.17	39	2.56	3.33
95	324.89	422.36	40	2.78	3.61
96	380.97	495.26	41	3.03	3.94
97	477.69	621.00	42	3.29	4.28
98	657.38	854.59	43	3.56	4.63
99	1000.00	1000.00	44	3.84	4.99

TABLE 3
 1980 CSO-C AND 1980 CET-C MORTALITY TABLES
 BASED ON BLENDING 1980 CSO AND 1980 CET
 MORTALITY TABLES 60 PERCENT MALE—
 40 PERCENT FEMALE
 (PIVOTAL AGE 45)
 RATES OF MORTALITY
 1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO-C	1980 CET-C	Age (x)	1980 CSO-C	1980 CET-C
0	3.67	4.77	45	4.15	5.40
			46	4.47	5.81
			47	4.81	6.25
			48	5.17	6.72
			49	5.58	7.25
			50	6.01	7.81
			51	6.50	8.45
			52	7.05	9.17
			53	7.68	9.98
			54	8.37	10.88
			55	9.11	11.84

Age (x)	1980 CSO-C	1980 CET-C	Age (x)	1980 CSO-D	1980 CET-D
56	9.88	12.84	1	.97	1.72
57	10.68	13.88	2	.91	1.66
58	11.50	14.95	3	.89	1.64
59	12.39	16.11	4	.85	1.60
60	13.37	17.38	5	.83	1.58
61	14.48	18.81	6	.79	1.54
62	15.79	20.53	7	.77	1.52
63	17.30	22.49	8	.73	1.48
64	19.01	24.71	9	.72	1.47
65	20.88	27.14	10	.71	1.46
66	22.84	29.69	11	.72	1.47
67	24.90	32.37	12	.78	1.53
68	27.04	35.15	13	.87	1.62
69	29.32	38.12	14	.97	1.72
70	31.92	41.50	15	1.10	1.85
71	34.90	45.37	16	1.21	1.96
72	38.38	49.89	17	1.31	2.06
73	42.48	55.22	18	1.39	2.14
74	47.11	61.24	19	1.44	2.19
75	52.16	67.81	20	1.48	2.23
76	57.58	74.85	21	1.49	2.24
77	63.24	82.21	22	1.50	2.25
78	69.13	89.87	23	1.49	2.24
79	75.41	98.03	24	1.49	2.24
80	82.34	107.04	25	1.47	2.22
81	90.17	117.22	26	1.47	2.22
82	99.12	128.86	27	1.46	2.21
83	109.33	142.13	28	1.48	2.23
84	120.58	156.75	29	1.51	2.26
85	132.68	172.48	30	1.54	2.29
86	145.47	189.11	31	1.58	2.33
87	158.84	206.49	32	1.64	2.39
88	172.87	224.73	33	1.70	2.45
89	187.54	243.80	34	1.79	2.54
90	203.08	264.00	35	1.88	2.63
91	219.76	285.69	36	2.00	2.75
92	238.20	309.66	37	2.14	2.89
93	259.26	337.04	38	2.31	3.06
94	285.17	370.72	39	2.51	3.26
95	322.03	418.64	40	2.72	3.54
96	378.56	492.14	41	2.97	3.86
97	476.70	619.71	42	3.22	4.19
98	657.10	854.23	43	3.49	4.54
99	1000.00	1000.00	44	3.75	4.88

TABLE 4
 1980 CSO-D AND 1980 CET-D MORTALITY TABLES
 BASED ON BLENDING 1980 CSO AND 1980 CET
 MORTALITY TABLES 50 PERCENT MALE—
 50 PERCENT FEMALE
 (PIVOTAL AGE 45)
 RATES OF MORTALITY
 1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO-D	1980 CET-D	Age (x)	1980 CSO-D	1980 CET-D
0	3.54	4.60	45	4.06	5.28
			46	4.36	5.67
			47	4.68	6.08
			48	5.03	6.54
			49	5.41	7.03
			50	5.83	7.58
			51	6.30	8.19
			52	6.82	8.87
			53	7.42	9.65
			54	8.07	10.49
			55	8.77	11.40

Age (x)	1980 CSO-D	1980 CET-D	Age (x)	1980 CSO-E	1980 CET-E
56	9.50	12.35	1	.95	1.70
57	10.23	13.30	2	.89	1.64
58	10.99	14.29	3	.86	1.61
59	11.81	15.35	4	.84	1.59
60	12.71	16.52	5	.81	1.56
61	13.75	17.88	6	.78	1.53
62	14.96	19.45	7	.76	1.51
63	16.39	21.31	8	.72	1.47
64	18.02	23.43	9	.71	1.46
65	19.78	25.71	10	.70	1.45
66	21.64	28.13	11	.71	1.46
67	23.59	30.67	12	.77	1.52
68	25.58	33.25	13	.84	1.59
69	27.73	36.05	14	.94	1.69
70	30.16	39.21	15	1.05	1.80
71	32.96	42.85	16	1.15	1.90
72	36.29	47.18	17	1.24	1.99
73	40.20	52.26	18	1.31	2.06
74	44.66	58.06	19	1.36	2.11
75	49.55	64.42	20	1.39	2.14
76	54.80	71.24	21	1.41	2.16
77	60.31	78.40	22	1.42	2.17
78	66.06	85.88	23	1.42	2.17
79	72.23	93.90	24	1.42	2.17
80	79.07	102.79	25	1.40	2.15
81	86.80	112.84	26	1.41	2.16
82	95.68	124.38	27	1.42	2.17
83	105.81	137.55	28	1.44	2.19
84	117.02	152.13	29	1.46	2.21
85	129.11	167.84	30	1.50	2.25
86	141.91	184.48	31	1.55	2.30
87	155.41	202.03	32	1.60	2.35
88	169.55	220.42	33	1.66	2.41
89	184.45	239.79	34	1.75	2.50
90	200.23	260.30	35	1.83	2.58
91	217.23	282.40	36	1.95	2.70
92	235.91	306.68	37	2.09	2.84
93	257.43	334.66	38	2.25	3.00
94	283.81	368.95	39	2.45	3.20
95	320.74	416.96	40	2.66	3.46
96	377.93	491.31	41	2.90	3.77
97	476.61	619.59	42	3.15	4.10
98	656.44	853.37	43	3.41	4.43
99	1000.00	1000.00	44	3.66	4.76
			45	3.96	5.15
			46	4.24	5.51
			47	4.55	5.92
			48	4.89	6.36
			49	5.26	6.84
			50	5.66	7.36
			51	6.10	7.93
			52	6.60	8.58
			53	7.16	9.31
			54	7.77	10.10
			55	8.43	10.96

TABLE 5
1980 CSO-E AND 1980 CET-E MORTALITY TABLES
BASED ON BLENDING 1980 CSO AND 1980 CET
MORTALITY TABLES 40 PERCENT MALE—
60 PERCENT FEMALE
(PIVOTAL AGE 45)
RATES OF MORTALITY
1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO-E	1980 CET-E
0	3.41	4.43

Age (x)	1980 CSO-E	1980 CET-E	Age (x)	1980 CSO-F	1980 CET-F
56	9.11	11.84	1	.92	1.67
57	9.79	12.73	2	.85	1.60
58	10.48	13.62	3	.82	1.57
59	11.23	14.60	4	.81	1.56
60	12.05	15.67	5	.79	1.54
61	13.01	16.91	6	.76	1.51
62	14.14	18.38	7	.74	1.49
63	15.50	20.15	8	.71	1.46
64	17.03	22.14	9	.70	1.45
65	18.71	24.32	10	.70	1.45
66	20.46	26.60	11	.70	1.45
67	22.31	29.00	12	.74	1.49
68	24.17	31.42	13	.80	1.55
69	26.18	34.03	14	.86	1.61
70	28.45	36.99	15	.95	1.70
71	31.10	40.43	16	1.03	1.78
72	34.27	44.55	17	1.09	1.84
73	38.02	49.43	18	1.15	1.90
74	42.32	55.02	19	1.19	1.94
75	47.05	61.17	20	1.22	1.97
76	52.18	67.83	21	1.24	1.99
77	57.57	74.84	22	1.25	2.00
78	63.21	82.17	23	1.27	2.02
79	69.29	90.08	24	1.28	2.03
80	76.04	98.85	25	1.29	2.04
81	83.72	108.84	26	1.30	2.05
82	92.52	120.28	27	1.31	2.06
83	102.65	133.45	28	1.35	2.10
84	113.82	147.97	29	1.38	2.13
85	125.93	163.71	30	1.42	2.17
86	138.78	180.41	31	1.47	2.22
87	152.39	198.11	32	1.52	2.27
88	166.68	216.68	33	1.58	2.33
89	181.76	236.29	34	1.66	2.41
90	197.78	257.11	35	1.74	2.49
91	215.12	279.66	36	1.85	2.60
92	234.03	304.24	37	1.99	2.74
93	255.85	332.61	38	2.15	2.90
94	282.58	367.35	39	2.32	3.07
95	319.76	415.69	40	2.54	3.30
96	377.41	490.63	41	2.77	3.60
97	476.21	619.07	42	3.02	3.93
98	656.10	852.93	43	3.25	4.23
99	1000.00	1000.00	44	3.49	5.54
			45	3.75	4.88
			46	4.02	5.23
			47	4.30	5.59
			48	4.61	5.99
			49	4.94	6.42
			50	5.31	6.90
			51	5.70	7.41
			52	6.15	8.00
			53	6.65	8.65
			54	7.19	9.35

TABLE 6
 1980 CSO-F AND 1980 CET-F MORTALITY TABLES
 BASED ON BLENDING 1980 CSO AND 1980 CET
 MORTALITY TABLES 20 PERCENT MALE—
 80 PERCENT FEMALE
 (PIVOTAL AGE 45)
 RATES OF MORTALITY
 1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO-F	1980 CET-F
0	3.15	4.10

Age (x)	1980 CSO-F	1980 CET-F	Age (x)	1980 CSO-G	1980 CET-G
55	7.76	10.09	1	.87	1.62
56	8.34	10.84	2	.81	1.56
57	8.91	11.58	3	.79	1.54
58	9.47	12.31	4	.77	1.52
59	10.08	13.10			
			5	.76	1.51
60	10.75	13.98	6	.73	1.48
61	11.55	15.02	7	.72	1.47
62	12.54	16.30	8	.70	1.45
63	13.74	17.86	9	.69	1.44
64	15.10	19.63			
			10	.68	1.43
65	16.62	22.61	11	.69	1.44
66	18.19	23.65	12	.72	1.47
67	19.81	25.75	13	.75	1.50
68	21.45	27.89	14	.80	1.55
69	23.19	30.15			
			15	.85	1.60
70	25.19	32.75	16	.90	1.65
71	27.57	35.84	17	.95	1.70
72	30.43	39.56	18	.98	1.73
73	33.92	44.10	19	1.02	1.77
74	37.94	49.32			
			20	1.05	1.80
75	42.43	55.16	21	1.07	1.82
76	47.33	61.53	22	1.09	1.84
77	52.53	68.29	23	1.11	1.86
78	58.03	75.44	24	1.14	1.89
79	63.98	83.17			
			25	1.16	1.91
80	70.65	91.85	26	1.19	1.94
81	78.26	101.74	27	1.22	1.97
82	87.04	113.15	28	1.26	2.01
83	97.15	126.30	29	1.30	2.05
84	108.33	140.83			
			30	1.35	2.10
85	120.52	156.68	31	1.40	2.15
86	133.53	173.59	32	1.45	2.20
87	147.37	191.58	33	1.50	2.25
88	161.93	210.51	34	1.58	2.33
89	177.40	230.62			
			35	1.65	2.40
90	193.80	251.94	36	1.76	2.51
91	211.61	275.09	37	1.89	2.64
92	231.05	300.37	38	2.04	2.79
93	253.44	329.47	39	2.22	2.97
94	280.66	364.86			
			40	2.42	3.17
95	318.37	413.88	41	2.64	3.43
96	376.21	489.07	42	2.87	3.73
97	475.72	618.44	43	3.09	4.02
98	656.09	852.92	44	3.32	4.32
99	1000.00	1000.00			

TABLE 7
1980 CSO-G AND 1980 CET-G MORTALITY TABLES
BASED ON BLENDING 1980 CSO AND 1980 CET
MORTALITY TABLES 0 PERCENT MALE—
100 PERCENT FEMALE
RATES OF MORTALITY
1,000 q_x AGE NEAREST BIRTHDAY

Age (x)	1980 CSO-G	1980 CET-G
0	2.89	3.76

45	3.56	4.63
46	3.80	4.94
47	4.05	5.27
48	4.33	5.63
49	4.63	6.02
50	4.96	6.45
51	5.31	6.90
52	5.70	7.41
53	6.15	8.00
54	6.61	8.59

Age (x)	1980 CSO-G	1980 CET-G	Age	Non- Smoker	Smoker
55	7.09	9.22	19	1.66	2.26
56	7.57	9.84	20	1.63	2.31
57	8.03	10.44	21	1.67	2.33
58	8.47	11.01	22	1.64	2.30
59	8.94	11.62	23	1.61	2.26
			24	1.57	2.21
60	9.47	12.31	25	1.52	2.14
61	10.13	13.17	26	1.48	2.08
62	10.96	14.25	27	1.46	2.06
63	12.02	15.63	28	1.44	2.04
64	13.25	17.23	29	1.44	2.06
			30	1.44	2.10
65	14.59	18.97	31	1.47	2.17
66	16.00	20.80	32	1.50	2.24
67	17.43	22.66	33	1.55	2.35
68	18.84	24.49	34	1.61	2.48
69	20.36	26.47	35	1.69	2.63
			36	1.77	2.81
70	22.11	28.74	37	1.88	3.04
71	24.23	31.50	38	2.00	3.30
72	26.87	34.93	39	2.14	3.60
73	30.11	39.14	40	2.29	3.94
74	33.93	44.11	41	2.47	4.34
			42	2.65	4.75
75	38.24	49.71	43	2.86	5.22
76	42.97	55.86	44	3.07	5.71
77	48.04	62.45	45	3.32	6.27
78	53.45	69.49	46	3.59	6.83
79	59.35	77.16	47	3.88	7.44
			48	4.19	8.08
80	65.99	85.79	49	4.54	8.80
81	73.60	95.68	50	4.91	9.50
82	82.40	107.12	51	5.35	10.44
83	92.53	120.29	52	5.86	11.42
84	103.81	134.95	53	6.43	12.54
			54	7.09	13.80
85	116.10	150.93	55	7.82	15.14
86	129.29	168.08	56	8.63	16.59
87	143.32	186.32	57	9.49	18.09
88	158.18	205.63	58	10.42	19.69
89	173.94	226.12	59	11.47	21.35
			60	12.64	23.19
90	190.75	247.98	61	13.94	25.26
91	208.87	271.53	62	15.42	27.59
92	228.81	297.45	63	17.11	30.23
93	251.51	326.96	64	19.02	33.14
94	279.31	363.10	65	21.13	36.29
			66	23.40	39.57
95	317.32	412.52	67	25.86	43.01
96	375.74	488.46	68	23.50	46.55
97	474.97	617.46	69	31.38	50.32
98	655.85	852.61	70	34.63	54.48
99	1000.00	1000.00	71	88.91	59.09
			72	42.56	64.33
			73	47.44	70.23
			74	52.92	76.66
			75	58.80	83.77
			76	65.06	91.10
			77	71.64	98.52
			78	78.47	105.91
			79	85.72	113.49
			80	93.67	121.59
			81	102.52	130.41
			82	112.52	140.20
			83	123.79	151.03

APPENDIX B

1980 CSO-SA Smoker Table 1

Age	Non- Smoker	Smoker
15	1.29	1.65
16	1.43	1.87
17	1.54	2.05
18	1.60	2.16

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
84	136.11	162.49
85	149.20	174.20
86	162.80	185.78
87	176.79	197.06
88	190.89	209.37
89	205.29	221.52
90	220.19	233.69
91	235.84	246.12
92	252.75	259.33
93	271.63	276.30
94	295.65	298.15
95	329.96	329.96
96	384.55	384.55
97	480.20	480.20
98	657.98	657.98
99	1000.00	1000.00

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
58	10.42	19.69
59	11.47	21.35
60	12.64	23.19
61	13.94	25.26
62	15.42	27.59
63	17.11	30.23
64	19.02	33.14
65	21.13	36.29
66	23.40	39.57
67	25.86	43.01
68	23.50	46.55
69	31.38	50.32
70	34.63	54.48
71	88.91	59.09
72	42.56	64.33
73	47.44	70.23
74	52.92	76.66
75	58.80	83.77
76	65.06	91.10
77	71.64	98.52
78	78.47	105.91
79	85.72	113.49
80	93.67	121.59
81	102.52	130.41
82	112.52	140.20
83	123.79	151.03
84	136.11	162.49
85	149.20	174.20
86	162.80	185.78
87	176.79	197.06
88	190.89	209.37
89	205.29	221.52
90	220.19	233.69
91	235.84	246.12
92	252.75	259.33
93	271.63	276.30
94	295.65	298.15
95	329.96	329.96
96	384.55	384.55
97	480.20	480.20
98	657.98	657.98
99	1000.00	1000.00

1980 CSO-NA Nonsmoker Table 2

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
15	1.29	1.65
16	1.43	1.87
17	1.54	2.05
18	1.60	2.16
19	1.66	2.26
20	1.63	2.31
21	1.67	2.33
22	1.64	2.30
23	1.61	2.26
24	1.57	2.21
25	1.52	2.14
26	1.48	2.08
27	1.46	2.06
28	1.44	2.04
29	1.44	2.06
30	1.44	2.10
31	1.47	2.17
32	1.50	2.24
33	1.55	2.35
34	1.61	2.48
35	1.69	2.63
36	1.77	2.81
37	1.88	3.04
38	2.00	3.30
39	2.14	3.60
40	2.29	3.94
41	2.47	4.34
42	2.65	4.75
43	2.86	5.22
44	3.07	5.71
45	3.32	6.27
46	3.59	6.83
47	3.88	7.44
48	4.19	8.08
49	4.54	8.80
50	4.91	9.50
51	5.35	10.44
52	5.86	11.42
53	6.43	12.54
54	7.09	13.80
55	7.82	15.14
56	8.63	16.59
57	9.49	18.09

1980 CET-SA Smoker Table 3

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
15	2.11	2.51
16	2.23	2.71
17	2.32	2.85
18	2.38	2.96
19	2.42	3.03
20	2.43	3.07
21	2.41	3.07
22	2.38	3.03
23	2.34	2.99
24	2.30	2.93
25	2.25	2.86
26	2.22	2.82
27	2.20	2.80
28	2.19	2.80
29	2.19	2.83
30	2.20	2.88
31	2.23	2.95

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
32	2.27	3.04
33	2.33	3.16
34	2.40	3.32
35	2.48	3.54
36	2.57	3.80
37	2.69	4.12
38	2.82	4.49
39	2.96	4.90
40	2.13	5.38
41	3.33	5.90
42	3.58	6.47
43	3.85	7.10
44	4.15	7.79
45	4.49	8.52
46	4.85	9.27
47	5.24	10.09
48	5.67	10.97
49	6.14	11.93
50	6.67	13.00
51	7.28	14.21
52	7.98	15.57
53	8.79	17.12
54	9.69	18.81
55	10.69	20.62
56	11.78	22.53
57	12.94	24.54
58	14.22	26.66
59	15.67	28.94
60	17.28	31.47
61	19.07	34.33
62	21.14	37.56
63	23.48	41.16
64	26.08	45.10
65	28.93	49.27
66	32.01	53.64
67	25.31	58.16
68	38.90	62.91
69	42.87	68.06
70	47.37	73.74
71	52.51	80.12
72	58.44	87.33
73	65.14	95.33
74	72.51	104.09
75	80.39	113.45
76	88.71	123.02
77	97.41	132.63
78	106.54	142.34
79	116.38	152.49
80	127.24	163.42
81	139.43	175.45
82	153.17	188.77
83	168.40	203.18
84	184.83	218.18
85	202.00	233.27
86	219.93	248.09
87	238.11	263.80
88	256.53	279.15
89	275.46	294.91
90	295.17	310.80
91	316.11	327.34
92	339.07	346.52
93	366.28	371.11
94	402.78	404.65
95	457.42	457.42
96	547.29	547.29

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
97	703.30	703.30
98	968.70	968.70
99	1000.00	1000.00

1980 CET-NA Non-Smoker Table 4

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
15	2.11	2.51
16	2.23	2.71
17	2.32	2.85
18	2.38	2.96
19	2.42	3.03
20	2.43	3.07
21	2.41	3.07
22	2.38	3.03
23	2.34	2.99
24	2.30	2.93
25	2.25	2.86
26	2.22	2.82
27	2.20	2.80
28	2.19	2.80
29	2.19	2.83
30	2.20	2.88
31	2.23	2.95
32	2.27	3.04
33	2.33	3.16
34	2.40	3.32
35	2.48	3.54
36	2.57	3.80
37	2.69	4.12
38	2.82	4.49
39	2.96	4.90
40	2.13	5.38
41	3.33	5.90
42	3.58	6.47
43	3.85	7.10
44	4.15	7.79
45	4.49	8.52
46	4.85	9.27
47	5.24	10.09
48	5.67	10.97
49	6.14	11.93
50	6.67	13.00
51	7.28	14.21
52	7.98	15.57
53	8.79	17.12
54	9.69	18.81
55	10.69	20.62
56	11.78	22.53
57	12.94	24.54
58	14.22	26.66
59	15.67	28.94
60	17.28	31.47
61	19.07	34.33
62	21.14	37.56
63	23.48	41.16
64	26.08	45.10
65	28.93	49.27
66	32.01	53.64
67	25.31	58.16
68	38.90	62.91
69	42.87	68.06
70	47.37	73.74

Age	Non-Smoker	Smoker	Age	1_x	$1000q_x$
71	52.51	80.12	42	209577	4.53
72	58.44	87.33	43	208628	4.97
73	65.14	95.33	44	207591	5.42
74	72.51	104.09	45	206466	5.94
75	80.39	113.45	46	205240	6.45
76	88.71	123.02	47	203916	7.01
77	97.41	132.63	48	202487	7.60
78	106.54	142.34	49	200948	8.25
79	116.38	152.49	50	199290	8.95
80	127.24	163.42	51	197506	9.74
81	139.43	175.45	52	195582	10.63
82	153.17	188.77	53	193503	11.64
83	168.40	203.18	54	191251	12.77
84	184.83	218.18	55	188809	13.96
85	202.00	233.27	56	186173	15.24
86	219.93	248.09	57	183336	16.55
87	238.11	263.80	58	180302	17.93
88	256.53	279.15	59	177069	19.36
89	275.46	294.91	60	173641	20.93
90	295.17	310.80	61	170007	22.72
91	316.11	327.34	62	166144	24.75
92	339.07	346.52	63	162032	27.09
93	366.28	371.11	64	157643	29.66
94	402.78	404.65	65	152967	32.45
95	457.42	457.42	66	148003	35.33
96	547.29	547.29	67	142774	38.33
97	703.30	703.30	68	137301	41.34
98	968.70	968.70	69	131625	44.56
99	1000.00	1000.00	70	125760	48.06
			71	119716	52.02
			72	113488	56.56
			73	107069	61.72
			74	100461	67.39
			75	93691	73.64
			76	86792	80.11
			77	79839	86.64
			78	72922	93.17
			79	66128	99.91
			80	59521	107.14
			81	53144	115.11
			82	47027	124.03
			83	41194	134.01
			84	35674	144.97
			85	30502	165.08
			86	25741	167.75
			87	21423	179.03
			88	17588	191.74
			89	14216	204.04
			90	11315	217.42
			91	8855	231.58
			92	6804	246.88
			93	5124	265.45
			94	3764	*289.36
			95	2675	*324.89
			96	1806	*380.97
			97	1118	*477.69
			98	584	*657.38
			99	200	1000.00

1980 CSO-SB SMOKER TABLE &
1980 CET-SB SMOKER TABLE #

Pivotal Age Is 45 *** Ratio of Male 1_x to Total Is 80%

1980 CSO-SB SMOKER TABLE 5

Age	1_x	$1000q_x$
15	223083	1.51
16	222746	1.70
17	222367	1.85
18	221956	1.95
19	221523	2.04
20	221071	2.09
21	220609	2.10
22	220146	2.09
23	219686	2.06
24	219233	2.03
25	218788	1.97
26	218357	1.93
27	217936	1.92
28	217518	1.92
29	217100	1.94
30	216679	1.99
31	216248	2.06
32	215803	2.13
33	215343	2.23
34	214863	2.35
35	214358	2.50
36	213822	2.67
37	213251	2.89
38	212635	3.14
39	211967	3.43
40	211240	3.75
41	210448	4.14

1980 CET-SB SMOKER TABLE 6

Age	1_x	$1000q_x$
15	4675331	2.26
16	4664765	2.45
17	4653336	2.60

Age	l_x	$1000q_x$
18	4641237	2.70
19	4628706	2.79
20	4615792	2.84
21	4602683	2.85
22	4589565	2.84
23	2576531	2.81
24	4563671	2.78
25	4550984	2.72
26	4538605	2.68
27	4526442	2.67
28	4514356	2.67
29	4502303	2.69
30	4490192	2.74
31	4477889	2.81
32	4465306	2.88
33	4452446	2.98
34	4439178	3.10
35	4425417	3.25
36	4411034	3.47
37	4395728	3.76
38	4379200	4.08
39	4361333	4.46
40	4341881	4.88
41	4320693	5.38
42	4297448	5.89
43	4272136	6.46
44	4244538	7.05
45	4214614	7.72
46	4182077	8.39
47	4146989	9.11
48	4109210	9.88
49	4068611	10.73
50	4024955	11.64
51	3978105	12.66
52	3927742	13.82
53	3873461	15.13
54	3814856	16.60
55	3751529	18.15
56	3683439	19.81
57	3610470	21.52
58	3532773	23.31
59	3450424	25.17
60	3363577	27.21
61	3272054	29.54
62	3175398	32.18
63	3073214	35.22
64	2964975	38.56
65	2850646	42.19
66	2730377	45.93
67	2604971	49.83
68	2475165	53.74
69	2342150	57.93
70	2206469	62.48
71	2068609	67.63
72	1928709	73.53
73	1786891	80.24
74	1643511	87.61
75	1499523	95.73
76	1355974	104.14
77	1214763	112.63
78	1077944	121.12
79	947383	129.88
80	824337	139.28
81	709523	149.64
82	603350	161.24
83	506066	174.21

Age	l_x	$1000q_x$
84	417904	188.46
85	339146	202.90
86	270333	218.08
87	211379	232.74
88	162183	249.26
89	121757	265.25
90	89461	282.65
91	64175	301.05
92	44855	320.94
93	30459	345.09
94	19948	376.17
95	12444	422.36
96	7188	495.26
97	3628	621.00
98	1375	854.59
99	200	1000.00

Age nearest birthday CSO: Sum $q_x = 4770.93$ Sum $l_x = 12302728$
 * Adjusted; see text CET: Sum $q_x = 8674.67$ Sum $l_x = 242009995$

1980 CSO-SC SMOKER TABLE &
 1980 CET-SC SMOKER TABLE #
 Pivotal Age Is 45 *** Ratio of Male l_x to Total Is 60%
 1980 CSO-SC SMOKER TABLE 7

Age	l_x	$1000q_x$
15	161242	1.37
16	161021	1.52
17	160776	1.65
18	160511	1.74
19	160232	1.82
20	159940	1.86
21	159643	1.88
22	159343	1.87
23	159045	1.85
24	158751	1.84
25	158459	1.81
26	158172	1.79
27	157889	1.79
28	157606	1.79
29	157324	1.83
30	157036	1.88
31	156741	1.95
32	156435	2.02
33	156119	2.11
34	155790	2.23
35	155443	2.35
36	155078	2.52
37	154687	2.74
38	154263	2.98
39	153803	3.25
40	153303	3.56
41	152757	3.94
42	152155	4.31
43	151499	4.71
44	150785	5.14
45	150010	5.61
46	149168	6.08
47	148261	6.59
48	147284	7.12
49	146235	7.71
50	145108	8.35
51	143896	9.05
52	142594	9.84
53	141191	10.75

Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
54	139673	11.75	30	2892288	2.63
55	138032	12.80	31	2884681	2.70
56	136265	13.92	32	2876892	2.77
57	134368	15.05	33	2868923	2.86
58	132346	16.21	34	2860718	2.98
59	130201	17.41	35	2852193	3.10
60	127934	18.74	36	2843351	3.28
61	125537	20.27	37	2834025	3.56
62	122992	22.02	38	2823936	3.87
63	120284	24.08	39	2813007	4.23
64	117388	26.36	40	2801108	4.63
65	114294	28.83	41	2788139	5.12
66	110999	31.35	42	2773864	5.60
67	107519	33.97	43	2758330	6.12
68	103867	36.55	44	2741449	6.68
69	100071	39.31	45	2723136	7.29
70	96137	42.29	46	2703284	7.90
71	92071	45.73	47	2681928	8.57
72	87861	49.75	48	2658944	9.26
73	83490	54.37	49	2634322	10.02
74	78951	59.53	50	2607926	10.86
75	74251	65.21	51	2579604	11.77
76	69409	71.12	52	2549242	12.79
77	64473	77.16	53	2516637	13.98
78	59498	83.23	54	2481454	15.28
79	54546	89.55	55	2443537	16.64
80	49661	96.42	56	2402877	18.10
81	44873	104.08	57	2359385	19.57
82	40203	112.72	58	2313212	21.07
83	35671	122.47	59	2264473	22.63
84	31302	133.48	60	2213228	24.36
85	27124	144.59	61	2159314	26.35
86	23202	156.67	62	2102416	28.63
87	19567	168.41	63	2042224	31.30
88	16272	181.66	64	1978302	34.27
89	13316	194.45	65	1910506	37.48
90	10727	208.76	66	1838900	40.76
91	8488	223.98	67	1763946	44.16
92	6587	240.65	68	1686050	47.52
93	5002	260.28	69	1605929	51.10
94	3700	*285.17	70	1523866	54.98
95	2645	*322.03	71	1440084	59.45
96	1793	*378.56	72	1354471	64.68
97	1114	*476.70	73	1266864	70.68
98	583	*657.10	74	1177322	77.39
99	200	1000.00	75	1086209	84.77
			76	994131	92.46
			77	902214	100.31
			78	811713	108.20
			79	723886	116.42
			80	639611	125.35
			81	559436	135.30
			82	483744	146.54
			83	412856	159.21
			84	347125	173.52
			85	286892	187.97
			86	232965	203.67
			87	185517	218.93
			88	144902	236.16
			89	110682	252.79
			90	82703	271.39
			91	60258	291.17
			92	42713	312.85
			93	29350	338.36
			94	19419	370.72
			95	12220	418.64

1980 CET-SC SMOKER TABLE 8

Age	l_x	$1000q_x$
15	3003428	2.12
16	2997061	2.27
17	2990258	2.40
18	2983081	2.49
19	2975653	2.57
20	2968006	2.61
21	2960260	2.63
22	2952475	2.62
23	2944740	2.60
24	2937084	2.59
25	2929477	2.56
26	2921978	2.54
27	2914556	2.54
28	2907153	2.54
29	2899769	2.58

Age	1_x	$1000q_x$
96	7104	492.13
97	3608	619.71
98	1372	854.23
99	200	1000.00

Age	1_x	$1000q_x$
66	99059	29.46
67	96141	31.91
68	93073	34.28
69	89882	36.86
70	86569	39.60
71	83141	42.85
72	79578	46.65
73	75866	51.06
74	71992	56.02
75	67959	61.49
76	63780	67.22
77	59493	73.10
78	55144	79.03
79	50786	85.26
80	46456	92.04
81	42180	99.64
82	37977	108.24
83	33866	117.99
84	29870	129.09
85	26014	140.30
86	22364	152.63
87	18951	164.55
88	15833	178.09
89	13013	191.10
90	10526	205.79
91	8360	221.41
92	6509	238.61
93	4956	258.45
94	3675	*283.81
95	2632	*320.74
96	1788	*377.93
97	1112	*476.61
98	582	*656.44
99	200	1000.00

Age nearest birthday CSO: Sum $qx = 4498.38$ Sum $1x = 9084082$
 * Adjusted; see text CET: Sum $qx = 8307.43$ Sum $1x = 158862096$

1980 CSO-SD SMOKER TABLE &
 1980 CET-SD SMOKER TABLE #

Pivotal Age is 45 *** Ratio of Male 1_x to Total Is 50%

1980 CSO-SD SMOKER TABLE 9

Age	1_x	$1000q_x$
15	141303	1.30
16	141119	1.44
17	140916	1.55
18	140698	1.63
19	140469	1.71
20	140229	1.74
21	139985	1.76
22	139739	1.76
23	139493	1.75
24	139249	1.74
25	139007	1.72
26	138768	1.71
27	138531	1.72
28	138293	1.73
29	138054	1.77
30	137810	1.82
31	137559	1.89
32	137299	1.96
33	137030	2.05
34	136749	2.17
35	136452	2.29
36	136140	2.45
37	135806	2.67
38	135443	2.90
39	135050	3.16
40	134623	3.47
41	134156	3.83
42	133642	4.20
43	133081	4.59
44	132470	4.99
45	131809	5.44
46	131092	5.89
47	130320	6.37
48	129490	6.88
49	128599	7.43
50	127644	8.04
51	126618	8.71
52	125515	9.46
53	124328	10.31
54	123046	11.25
55	121662	12.23
56	120174	13.26
57	118580	14.30
58	116884	15.36
59	115089	16.46
60	113195	17.67
61	111195	19.07
62	109075	20.69
63	106818	22.62
64	104402	24.76
65	101817	27.09

1980 CET-SD SMOKER TABLE 10

Age	1_x	$1000q_x$
15	2503786	2.05
16	2498653	2.19
17	2493181	2.30
18	2487447	2.38
19	2481527	2.46
20	2475422	2.49
21	2469258	2.51
22	2463060	2.51
23	2456878	2.50
24	2450736	2.49
25	2444634	2.47
26	2438596	2.46
27	2432597	2.47
28	2426588	2.48
29	2420570	2.52
30	2414470	2.57
31	2408265	2.64
32	2401907	2.71
33	2395398	2.80
34	2388691	2.92
35	2381716	3.04
36	2374476	3.20
37	2366878	3.47
38	2358665	3.77
39	2349773	4.11
40	2340115	4.51
41	2329561	4.98
42	2317960	5.46

Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
43	2305304	5.97	16	125581	1.35
44	2291541	6.49	17	125411	1.45
45	2276669	7.07	18	125229	1.52
46	2260573	7.66	19	125039	1.59
47	2243257	8.28	20	124840	1.63
48	2224683	8.94	21	124637	1.65
49	2204794	9.66	22	124431	1.65
50	2183496	10.45	23	124226	1.65
51	2160678	11.32	24	124021	1.65
52	2136219	12.30	25	123816	1.64
53	2109944	13.40	26	123613	1.64
54	2081671	14.63	27	123410	1.66
55	2051216	15.90	28	123205	1.67
56	2018602	17.24	29	122999	1.71
57	1983801	18.59	30	122789	1.77
58	1946922	19.97	31	122572	1.84
59	1908042	21.40	32	122346	1.91
60	1867210	22.97	33	122112	1.99
61	1824320	24.79	34	121869	2.11
62	1779095	26.90	35	121612	2.22
63	1731237	29.41	36	121342	2.38
64	1680321	32.19	37	121053	2.59
65	1626231	35.22	38	120739	2.82
66	1568955	38.30	39	120399	3.08
67	1508864	41.48	40	120028	3.38
68	1446276	44.56	41	119622	3.73
69	1381830	47.92	42	119176	4.09
70	1315613	51.48	43	118689	4.46
71	1247885	55.71	44	118160	4.85
72	1178365	60.65	45	117587	5.28
73	1106897	66.38	46	116966	5.70
74	1033421	72.83	47	116299	6.16
75	958157	79.94	48	115583	6.64
76	881562	87.39	49	114816	7.16
77	804522	95.03	50	113994	7.74
78	728068	102.74	51	113112	8.36
79	653266	110.84	52	112166	9.07
80	580858	119.65	53	111149	9.87
81	511358	129.53	54	110052	10.74
82	445122	140.71	55	108870	11.65
83	382489	153.39	56	107602	12.61
84	323819	167.82	57	106245	13.57
85	269476	182.39	58	104803	14.52
86	220326	198.42	59	103281	15.51
87	176609	213.92	60	101679	16.61
88	138829	231.52	61	99990	17.89
89	106687	248.43	62	98201	19.38
90	80183	267.53	63	96298	21.20
91	58732	287.83	64	94256	23.20
92	41827	310.19	65	92069	25.40
93	28853	335.99	66	89730	27.62
94	19159	368.95	67	87252	29.91
95	12090	416.96	68	84642	32.12
96	7049	491.31	69	81923	34.50
97	3586	619.59	70	79097	37.05
98	1364	853.37	71	76166	40.10
99	200	1000.00	72	73112	43.72
			73	69916	47.97
			74	66562	52.76
			75	63050	58.07
			76	59389	63.65
			77	55609	69.39
			78	51750	75.26
			79	47855	81.40
			80	43960	88.17
			81	40084	95.75

Age nearest birthday CSO: Sum qx = 4385.48 Sum lx = 8045842
 * Adjusted; see text CET: Sum qx = 8155.96 Sum lx = 133888931

1980 CSO-SE SMOKER TABLE &
 1980 CET-SE SMOKER TABLE #

Pivotal Age is 45 *** Ratio of Male l_x to Total is 40%

1980 CSO-SE SMOKER TABLE 11

Age	l_x	$1000q_x$
15	125734	1.22

Age	l_x	$1000q_x$	Age	l_x	$1000q_x$
82	36246	104.35	58	1674667	18.88
83	32464	114.13	59	1643049	20.16
84	28759	125.35	60	1609925	21.59
85	25154	136.67	61	1575167	23.26
86	21716	149.23	62	1538529	25.19
87	18475	161.37	63	1499773	27.56
88	15494	175.15	64	1458439	30.16
89	12780	188.35	65	1414452	33.02
90	10373	203.38	66	1367747	35.91
91	8263	219.41	67	1318631	38.88
92	6450	236.87	68	1267363	41.76
93	4922	257.15	69	1214438	44.85
94	2656	*282.58	70	1159970	48.17
95	2623	*319.76	71	1104094	52.13
96	1784	*377.41	72	1046538	56.84
97	1111	*476.21	73	987053	62.36
98	582	*656.10	74	925500	68.59
99	200	1000.00	75	862020	75.49
			76	796946	82.75
			77	730999	90.21
			78	665056	97.84
			79	599987	105.82
			80	536496	114.62
			81	475003	124.48
			82	415875	135.66
			83	359457	148.37
			84	306124	162.96
			85	256238	177.67
			86	210712	194.00
			87	169834	209.78
			88	134206	227.70
			89	103647	244.86
			90	78268	264.39
			91	57575	285.23
			92	41153	307.93
			93	28481	334.30
			94	18960	367.35
			95	11995	415.69
			96	7009	490.63
			97	3570	619.07
			98	1360	852.93
			99	200	1000.00

1980 CET-SE SMOKER TABLE 12

Age	l_x	$1000q_x$
15	2133421	1.97
16	2129228	2.10
17	2124757	2.20
18	2120083	2.27
19	1225270	2.34
20	2110320	2.38
21	2105297	2.40
22	2100244	2.40
23	2095203	2.40
24	2090175	2.40
25	2085159	2.39
26	2080175	2.39
27	2075203	2.41
28	2070202	2.42
29	2065192	2.46
30	2060112	2.52
31	2054921	2.59
32	2049599	2.66
33	2044147	2.74
34	2038546	2.86
35	2032716	2.97
36	2026679	3.13
37	2020335	3.37
38	2013526	3.67
39	2006136	4.00
40	1998111	4.39
41	1989339	4.85
42	1979691	5.32
43	1969159	5.80
44	1957738	6.31
45	1945385	6.86
46	1932040	7.41
47	1917724	8.01
48	1902363	8.63
49	1885946	9.31
50	1868388	10.06
51	1849592	10.87
52	1829487	11.79
53	1807917	12.83
54	1784721	13.96
55	1759806	15.15
56	1733145	16.39
57	1704739	17.64

Age nearest birthday CSO: Sum q_x = 4284.01 Sum l_x = 7234867
 * Adjusted; see text CET: Sum q_x = 8020.06 Sum l_x = 115338453

1980 CSO-SF SMOKER TABLE &
 1980 CET-SF SMOKER TABLE #
 Pivotal Age is 45 *** Ratio of Male l_x to Total Is 20%

1980 CSO-SF SMOKER TABLE 13

Age	l_x	$1000q_x$
15	102794	1.08
16	102683	1.17
17	102563	1.25
18	102435	1.31
19	102301	1.36
20	102162	1.39
21	102020	1.42
22	101875	1.43
23	101729	1.44
24	101583	1.46
25	101435	1.47
26	101286	1.49
27	101135	1.52

<u>Age</u>	<u>1_x</u>	<u>1000q_x</u>
28	100981	1.54
29	100825	1.60
30	100664	1.66
31	100497	1.72
32	100324	1.80
33	100143	1.87
34	99956	1.98
35	99758	2.08
36	99551	2.23
37	99329	2.44
38	99087	2.65
39	98824	2.90
40	98537	3.19
41	98223	3.53
42	97876	3.86
43	97498	4.21
44	97088	4.56
45	96645	4.94
46	96168	5.33
47	95655	5.74
48	95106	6.16
49	94520	6.62
50	93894	7.14
51	93224	7.68
52	92508	8.29
53	91741	9.00
54	90915	9.74
55	90029	10.52
56	89082	11.33
57	88073	12.11
58	87006	12.87
59	85886	13.66
60	84713	14.53
61	83482	15.59
62	82181	16.84
63	80797	18.43
64	79308	20.20
65	77706	22.15
66	75985	24.10
67	74154	26.12
68	72217	28.01
69	70194	30.09
70	68082	32.29
71	65884	35.04
72	63575	38.36
73	61136	42.33
74	58548	46.89
75	55803	51.94
76	52905	57.33
77	49872	62.93
78	46734	68.70
79	43523	74.83
80	40266	81.61
81	36980	89.22
82	33681	97.92
83	30383	107.82
84	27107	119.31
85	23873	130.86
86	20749	143.85
87	17764	156.39
88	14986	170.57
89	12430	184.17
90	10141	199.71
91	8116	216.27
92	6361	234.41
93	4870	255.00

<u>Age</u>	<u>1_x</u>	<u>1000q_x</u>
94	3628	*280.66
95	2610	*318.37
96	1779	*376.21
97	1110	*475.72
98	582	*656.09
99	200	1000.00

1980 CET-SF SMOKER TABLE 14

<u>Age</u>	<u>1_x</u>	<u>1000q_x</u>
15	1629026	1.83
16	1626045	1.92
17	1622923	2.00
18	1619677	2.06
19	1616340	2.11
20	1612930	2.14
21	1609478	2.17
22	1605985	2.18
23	1602484	2.19
24	1598975	2.21
25	1595441	2.22
26	1591899	2.24
27	1588333	2.27
28	1584727	2.29
29	1581098	2.35
30	1577382	2.41
31	1573581	2.47
32	1569694	2.55
33	1565691	2.62
34	1561589	2.73
35	1557326	2.83
36	1552919	2.98
37	1548291	3.19
38	1543352	3.45
39	1538027	3.77
40	1532229	4.15
41	1525870	4.59
42	1518866	5.02
43	1511241	5.47
44	1502975	5.93
45	1494062	6.42
46	1484470	6.93
47	1474183	7.46
48	1463186	8.01
49	1451466	8.61
50	1438969	9.28
51	1425615	9.98
52	1411387	10.78
53	1396172	11.70
54	1379837	12.66
55	1362368	13.68
56	1343731	14.73
57	1323938	15.74
58	1303099	16.73
59	1281298	17.76
60	1258542	18.89
61	1234768	20.27
62	1209739	21.89
63	1183258	23.96
64	1154907	26.26
65	1124579	28.80
66	1092191	31.33
67	1057973	33.96
68	1022044	36.41
69	984831	39.12

Age	<u>1_x</u>	<u>1000q_x</u>	Age	<u>1_x</u>	<u>1000q_x</u>
70	946304	41.98	40	112325	2.25
71	906578	45.55	41	112072	2.43
72	865283	49.87	42	111800	2.60
73	822131	55.03	43	111509	2.81
74	776889	60.96	44	111196	3.01
75	729530	67.52	45	110861	3.26
76	680272	74.53	46	110500	3.51
77	629571	81.81	47	110112	3.78
78	578066	89.31	48	109696	4.09
79	526439	97.28	49	109247	4.41
80	475227	106.09	50	108765	4.76
81	424810	115.99	51	108247	5.18
82	375536	127.30	52	107686	5.65
83	327730	140.17	53	107078	6.19
84	281792	155.10	54	106415	6.81
85	238086	170.12	55	105690	7.48
86	197583	187.02	56	104899	8.21
87	160633	203.31	57	104038	9.00
88	127975	221.74	58	103102	9.84
89	99598	239.42	59	102087	10.75
90	75752	259.62	60	100990	11.80
91	56085	281.15	61	99798	12.96
92	40317	304.73	62	98505	14.30
93	28031	331.50	63	97096	15.86
94	18739	364.86	64	95556	17.62
95	11902	413.88	65	93872	19.55
96	6976	489.07	66	92037	21.64
97	3564	618.44	67	90045	23.87
98	1360	852.92	68	87896	26.24
99	200	1000.00	69	85590	28.82
			70	83123	31.74
			71	80485	35.51
			72	77627	38.89
			73	74608	43.37
			74	71372	48.39
			75	67918	53.84
			76	64261	59.65
			77	60428	65.77
			78	56454	72.13
			79	52382	78.92
			80	48248	86.40
			81	440079	94.77
			82	39902	104.26
			83	35742	115.02
			84	31631	126.80
			85	27620	139.45
			86	23768	152.61
			87	20141	166.38
			88	16790	180.45
			89	13760	195.03
			90	11076	210.29
			91	8747	*226.51
			92	6766	*244.13
			93	5114	*264.04
			94	3764	*289.36
			95	2675	*324.89
			96	1806	*380.97
			97	1118	*477.69
			98	584	*657.38
			99	200	1000.00

Age nearest birthday CSO: Sum q_x = 4106.55 Sum 1_x = 6040029

* Adjusted; see text CET: Sum q_x = 7783.96 Sum 1_x = 90033966

1980 CSO-NB NON-SMOKER TABLE &
1980 CET-NB NON-SMOKER TABLE #

Pivotal Age Is 45 *** Ratio of Male 1_x to Total Is 80%

1980 CSO-NB NON-SMOKER TABLE 15

Age	<u>1_x</u>	<u>1000q_x</u>
15	116700	1.20
16	116560	1.32
17	116406	1.42
18	116241	1.47
19	116070	1.52
20	115894	1.55
21	115714	1.55
22	115535	1.52
23	115359	1.50
24	115186	1.47
25	115017	1.44
26	114851	1.41
27	114689	1.40
28	114528	1.38
29	114370	1.40
30	114210	1.40
31	114050	1.43
32	113887	1.46
33	113721	1.50
34	113550	1.58
35	113371	1.64
36	113185	1.73
37	112989	1.83
38	112782	1.96
39	112561	2.10

1980 CET-NB NON-SMOKER TABLE 16

Age	<u>1_x</u>	<u>1000q_x</u>
15	1977580	1.95

Age	<u>l_x</u>	<u>1000q_x</u>
16	1973724	2.07
17	1969638	2.17
18	1965364	2.22
19	1961001	2.27
20	1956550	2.30
21	1952050	2.30
22	1947560	2.27
23	1943139	2.25
24	1938767	2.22
25	1934463	2.19
26	1930227	2.16
27	1926058	2.15
28	1921917	2.13
29	1917823	2.15
30	1913700	2.15
31	1909586	2.18
32	1905423	2.21
33	1901212	2.25
34	1896934	2.33
35	1892514	2.39
36	1887991	2.48
37	1883309	2.58
38	1878450	2.71
39	1873359	2.85
40	1868020	3.00
41	1862416	3.18
42	1856494	3.38
43	1850219	3.65
44	1843466	3.91
45	1836258	4.24
46	1828472	4.56
47	1820134	4.91
48	1811197	5.32
49	1801561	5.73
50	1791238	6.19
51	1780150	6.73
52	1768170	7.35
53	1755174	8.05
54	1741045	8.85
55	1725637	9.72
56	1708864	10.67
57	1690630	11.70
58	1670850	12.79
59	1649480	13.98
60	1626420	15.34
61	1601471	16.85
62	1574486	18.59
63	1545216	20.62
64	1513354	22.91
65	1478683	25.42
66	1441095	28.13
67	1400557	31.03
68	1357098	34.11
69	1310807	37.47
70	1261691	41.26
71	1209634	46.16
72	1153797	50.56
73	1095461	56.38
74	1033699	62.91
75	968669	69.99
76	900872	77.55
77	831009	85.50
78	759958	93.77
79	688697	102.60
80	618037	112.32
81	548619	123.20

Age	<u>l_x</u>	<u>1000q_x</u>
82	481029	135.54
83	415830	149.53
84	353651	164.84
85	295355	181.29
86	241810	198.39
87	193837	216.29
88	151912	234.59
89	116275	253.54
90	86795	273.38
91	63067	294.46
92	44496	317.37
93	30374	343.25
94	19948	376.17
95	12444	422.36
96	7188	495.26
97	3628	621.00
98	1375	854.59
99	200	1000.00

Age nearest birthday CSO: Sum q_x= 3436.53 Sum l_x= 7008325
 * Adjusted; see text CET: Sum q_x= 7899.36 Sum l_x= 112256358

1980 CSO-NC NON-SMOKER TABLE &
 1980 CET-NC NON-SMOKER TABLE #
 Pivotal Age Is 45 *** Ratio of Male l_x to Total Is 60%
 1980 CSO-NC NON-SMOKER TABLE 17

Age	<u>l_x</u>	<u>1000q_x</u>
15	95229	1.11
16	95123	1.22
17	95007	1.29
18	94884	1.34
19	94757	1.39
20	94625	1.41
21	94492	1.42
22	94358	1.40
23	94226	1.39
24	94095	1.37
25	93966	1.35
26	93839	1.33
27	93714	1.33
28	93589	1.33
29	93465	1.35
30	93339	1.36
31	93212	1.39
32	93082	1.42
33	92950	1.47
34	92813	1.53
35	92671	1.60
36	92523	1.68
37	92368	1.80
38	92202	1.91
39	92026	2.06
40	91836	2.21
41	91633	2.38
42	91415	2.57
43	91180	2.76
44	90928	2.96
45	90659	3.19
46	90370	3.43
47	90060	3.69
48	89728	3.98
49	89371	4.28
50	88988	4.62
51	88577	5.00

<u>Age</u>	<u>1_x</u>	<u>1000q_x</u>	<u>Age</u>	<u>1_x</u>	<u>1000q_x</u>
52	88134	5.46	28	1455427	2.08
53	87653	5.96	29	1452400	2.10
54	87131	6.52	30	1449350	2.11
55	86563	7.14	31	1446292	2.14
56	85945	7.80	32	1443197	2.17
57	85275	8.51	33	1440065	2.22
58	84549	9.24	34	1436868	2.28
59	83768	10.05	35	1433592	2.35
60	82926	10.97	36	1430223	2.43
61	82016	12.01	37	1426748	2.55
62	81031	13.21	38	1423110	2.66
63	79961	14.62	39	1419325	2.81
64	78792	16.24	40	1415337	2.96
65	77512	18.01	41	1411148	3.13
66	76116	19.91	42	1406731	3.34
67	74601	21.94	43	1402033	3.59
68	72964	24.05	44	1397000	3.85
69	71209	26.35	45	1391622	4.15
70	69333	28.95	46	1385847	4.46
71	67326	32.26	47	1379666	4.80
72	65154	35.42	48	1373044	5.17
73	62846	39.52	49	1365945	5.56
74	60362	44.17	50	1358350	6.01
75	57696	49.24	51	1350186	6.50
76	54855	54.70	52	1341410	7.10
77	51854	60.43	53	1331886	7.75
78	48720	66.46	54	1321564	8.48
79	45482	72.92	55	1310357	9.28
80	42165	80.06	56	1298197	10.14
81	38789	88.10	57	1285033	11.06
82	35372	97.27	58	1270821	12.01
83	31931	107.73	59	1255558	13.07
84	28491	119.23	60	1239148	14.26
85	25094	131.61	61	1221478	15.61
86	21791	144.68	62	1202411	17.17
87	18638	158.40	63	1181766	19.01
88	15686	172.60	64	1159301	21.11
89	12979	187.46	65	1134828	23.41
90	10546	*203.08	66	1108262	25.88
91	8404	*219.76	67	1079580	28.52
92	6557	*238.20	68	1048790	31.27
93	4995	*259.26	69	1015994	34.26
94	3700	*285.17	70	981186	37.64
95	2645	*322.03	71	944254	41.94
96	1793	*378.56	72	904652	46.05
97	1114	*476.70	73	862993	51.38
98	583	*657.10	74	818652	57.42
99	200	1000.00	75	771645	64.01
			76	722252	71.11
			77	670893	78.56
			78	618188	86.40
			79	564777	94.80
			80	511236	104.08
			81	458027	114.53
			82	405569	126.45
			83	354285	140.05
			84	304667	155.00
			85	257444	171.09
			86	213398	188.08
			87	173262	205.92
			88	137584	224.38
			89	106713	243.70
			90	80707	264.00
			91	59400	285.69
			92	42430	309.66
			93	29291	337.04

1980 CET-NC NON-SMOKER TABLE 18

<u>Age</u>	<u>1_x</u>	<u>1000q_x</u>
15	1495453	1.86
16	1492671	1.97
17	1489730	2.04
18	1486691	2.09
19	1483584	2.14
20	1480409	2.16
21	1477211	2.17
22	1474005	2.15
23	1470836	2.14
24	1467688	2.12
25	1464577	2.10
26	1461501	2.08
27	1458461	2.08

Age	<u>1_x</u>	<u>1000q_x</u>
94	19419	370.72
95	12220	418.64
96	7104	492.13
97	3608	619.71
98	1372	854.23
99	200	1000.00

Age	<u>1_x</u>	<u>1000q_x</u>
64	72492	15.56
65	71364	17.24
66	70134	19.07
67	68797	20.98
68	67354	22.99
69	65806	25.15
70	64151	27.60
71	62380	30.69
72	60466	33.75
73	58425	37.67
74	56224	42.16
75	53854	47.06
76	51320	52.38
77	48632	57.96
78	45813	63.84
79	42888	70.16
80	39879	77.18
81	36801	85.11
82	33669	94.17
83	30498	104.54
84	27310	115.93
85	24144	128.27
86	21047	141.31
87	18073	155.09
88	15270	169.35
89	12684	184.40
90	10345	*200.23
91	8274	*217.23
92	6477	*235.91
93	4949	*257.43
94	3675	*283.81
95	2632	*320.74
96	1788	*377.93
97	1112	*476.61
98	582	*656.44
99	200	1000.00

Age nearest birthday CSO: Sum q_x = 3086.52 Sum 1_x = 5788547
 * Adjusted; see text CET: Sum q_x = 7672.32 Sum 1_x = 85940135

1980 CSO-ND NON-SMOKER TABLE &
 1980 CET-ND NON-SMOKER TABLE #

Pivotal Age Is 45 *** Ratio of Male 1_x to Total Is 50%

1980 CSO-ND NON-SMOKER TABLE 19

Age	<u>1_x</u>	<u>1000q_x</u>
15	87164	1.07
16	87071	1.16
17	86970	1.23
18	86863	1.27
19	86753	1.32
20	86638	1.35
21	86521	1.34
22	86405	1.34
23	86289	1.33
24	86174	1.33
25	86059	1.30
26	85947	1.30
27	85835	1.29
28	85724	1.31
29	85612	1.33
30	85498	1.34
31	85383	1.37
32	85266	1.40
33	85147	1.45
34	85024	1.51
35	84896	1.58
36	84762	1.67
37	84620	1.77
38	84470	1.90
39	84310	2.03
40	84139	2.19
41	83955	2.36
42	83757	2.55
43	83543	2.73
44	83315	2.93
45	83071	3.16
46	82808	3.39
47	82527	3.65
48	82226	3.92
49	81904	4.22
50	81558	4.55
51	81187	4.92
52	80788	5.36
53	80355	5.85
54	79885	6.38
55	79375	6.97
56	78822	7.60
57	78223	8.26
58	77577	8.95
59	76883	9.70
60	76137	10.55
61	75334	11.53
62	74465	12.66
63	73522	14.01

1980 CET-ND NON-SMOKER TABLE 20

Age	<u>1_x</u>	<u>1000q_x</u>
15	1321831	1.82
16	1319425	1.91
17	1316905	1.98
18	1314298	2.02
19	1311643	2.07
20	1308928	2.10
21	1306179	2.09
22	1303449	2.09
23	1300725	2.08
24	1298019	2.08
25	1295319	2.05
26	1292664	2.05
27	1290014	2.04
28	1287382	2.06
29	1284730	2.08
30	1282058	2.09
31	1279378	2.12
32	1276666	2.15
33	1273921	2.20
34	1271118	2.26
35	1268245	2.33
36	1265290	2.42
37	1262228	2.52
38	1259047	2.65
39	1255711	2.78
40	1252220	2.94
41	1248538	3.11
42	1244655	3.32

<u>Age</u>	<u>1_x</u>	<u>1000q_x</u>	<u>Age</u>	<u>1_x</u>	<u>1000q_x</u>
43	1240523	3.55	16	80362	1.10
44	1236119	3.81	17	80274	1.17
45	1231409	4.11	18	80180	1.21
46	1226348	4.41	19	80083	1.25
47	1220940	4.75	20	79983	1.29
48	1215141	5.10	21	79880	1.28
49	1208944	5.49	22	79778	1.28
50	1202307	5.92	23	79676	1.28
51	1195189	6.40	24	79574	1.28
52	1187540	6.97	25	79472	1.26
53	1179263	7.61	26	79372	1.26
54	1170289	8.29	27	79272	1.27
55	1160587	9.06	28	79171	1.28
56	1150072	9.88	29	79070	1.30
57	1138709	10.74	30	78967	1.31
58	1126479	11.64	31	78864	1.36
59	1113367	12.61	32	78757	1.39
60	1099327	13.72	33	78648	1.42
61	1084244	14.99	34	78536	1.49
62	1067991	16.46	35	78419	1.56
63	1050412	18.21	36	78297	1.65
64	1031284	20.23	37	78168	1.76
65	1010421	22.41	38	78030	1.87
66	987777	24.79	39	77884	2.02
67	963290	27.27	40	77727	2.16
68	937021	29.89	41	77559	2.34
69	909013	32.70	42	77378	2.53
70	879288	35.88	43	77182	2.72
71	847739	39.90	44	76972	2.91
72	813914	43.88	45	76748	3.13
73	778199	48.97	46	76508	3.35
74	740091	54.81	47	76252	3.59
75	699527	61.18	48	75978	3.87
76	656730	68.09	49	75684	4.15
77	612013	75.35	50	75370	4.48
78	565898	82.99	51	75032	4.84
79	518934	91.21	52	74669	5.25
80	471602	100.33	53	74277	5.73
81	424286	110.64	54	73851	6.23
82	377343	122.42	55	73391	6.81
83	331149	135.90	56	72891	7.39
84	286146	150.71	57	72352	8.02
85	243021	166.75	58	71772	8.65
86	202497	183.70	59	71151	9.35
87	165298	201.62	60	70486	10.14
88	131971	220.16	61	69771	11.04
89	102916	239.72	62	69001	12.12
90	78245	260.30	63	68165	13.40
91	57878	282.40	64	67252	14.89
92	41533	306.68	65	66251	16.49
93	28796	334.66	66	65159	18.23
94	19159	368.95	67	63971	20.04
95	12090	416.96	68	62689	21.93
96	7049	491.31	69	61314	23.96
97	3586	619.59	70	59845	26.28
98	1364	853.37	71	58272	29.16
99	200	1000.00	72	56573	32.11
			73	54756	35.90
			74	52790	40.21
			75	50667	44.98
			76	48388	50.15
			77	45961	55.59
			78	43406	61.36
			79	40743	67.55
			80	37991	74.48
			81	35161	82.32

Age nearest birthday CSO: Sum qx = 3023.29 Sum 1x = 5330266
 * Adjusted; see text CET: Sum qx = 7572.85 Sum 1x = 76433054

1980 CSO-NE NON-SMOKER TABLE &
 1980 CET-NE NON-SMOKER TABLE #
 Pivotal Age Is 45 *** Ratio of Male 1_x to Total is 40%
 1980 CSO-NE NON-SMOKER TABLE 21

<u>Age</u>	<u>1_x</u>	<u>1000q_x</u>
15	80445	1.03

Age	<u>1_x</u>	<u>1000q_x</u>	Age	<u>1_x</u>	<u>1000q_x</u>
82	32267	91.29	58	1010426	11.25
83	29321	101.59	59	999059	12.16
84	26342	112.91	60	968910	13.18
85	23368	125.24	61	973903	14.35
86	20441	138.25	62	959927	15.76
87	17615	152.08	63	944799	17.42
88	14936	166.50	64	928341	19.36
89	12449	181.73	65	910368	21.44
90	10187	*197.78	66	890850	23.70
91	8172	*215.12	67	869737	26.05
92	6414	*234.03	68	847080	28.51
93	4913	*255.85	69	822930	31.15
94	3656	*282.58	70	797296	34.16
95	2623	*319.76	71	770060	37.91
96	1784	*377.41	72	740867	41.74
97	1111	*476.21	73	709943	46.67
98	582	*656.10	74	676810	52.27
99	200	1000.00	75	641433	58.47
			76	603928	65.20
			77	564552	72.27
			78	523752	79.77
			79	481972	87.72
			80	439645	96.82
			81	397079	107.02
			82	354584	118.68
			83	312502	132.07
			84	271230	146.78
			85	231419	162.81
			86	193742	179.73
			87	158921	197.70
			88	127502	216.45
			89	99904	236.25
			90	76302	257.11
			91	56684	379.66
			92	40832	304.24
			93	28409	332.61
			94	18960	367.35
			95	11995	415.69
			96	7009	490.63
			97	3570	619.70
			98	1360	852.93
			99	200	1000.00

1980 CET-NE NON-SMOKER TABLE 22

Age	<u>1_x</u>	<u>1000q_x</u>
15	1182241	1.78
16	1180137	1.85
17	1177954	1.92
18	1175692	1.96
19	1173388	2.00
20	1171041	2.04
21	1168652	2.03
22	1166280	2.03
23	1163912	2.03
24	1161549	2.03
25	1159191	2.01
26	1156861	2.01
27	1154536	2.02
28	1152204	2.03
29	1149865	2.05
30	1147508	2.06
31	1145144	2.11
32	1142728	2.14
33	1140283	2.17
34	1137809	2.24
35	1135260	2.31
36	1132638	2.40
37	1129920	2.51
38	1127084	2.62
39	1124131	2.77
40	1121017	2.91
41	1117755	3.09
42	1114301	3.29
43	1110635	3.54
44	1106703	3.78
45	1102520	4.07
46	1098033	4.36
47	1093246	4.67
48	1088141	5.03
49	1082668	5.40
50	1076822	5.82
51	1070555	6.29
52	1063821	6.83
53	1056555	7.45
54	1048684	8.10
55	1040190	8.85
56	1030984	9.61
57	1021076	10.43

Age nearest birthday CSO: Sum q_x = 2963.79 Sum 1_x = 4948899
 * Adjusted; see text CET: Sum q_x = 7480.85 Sum 1_x = 68786506

1980 CSO-NF NON-SMOKER TABLE &
 1980 CET-NF NON-SMOKER TABLE #
 Pivotal Age Is 45 *** Ratio of Male 1_x to Total is 20%

1980 CSO-NF NON-SMOKER TABLE 23

Age	<u>1_x</u>	<u>1000q_x</u>
15	69713	0.94
16	69647	0.99
17	69578	1.04
18	69506	1.07
19	69432	1.12
20	69354	1.15
21	69274	1.14
22	69195	1.16
23	69115	1.16
24	69035	1.18
25	68954	1.17
26	68873	1.19
27	68791	1.20

Age	l_x	$1000q_x$
28	68708	1.23
29	68623	1.25
30	68537	1.28
31	68449	1.32
32	68359	1.35
33	68267	1.38
34	68173	1.45
35	68074	1.51
36	67971	1.61
37	67862	1.71
38	67746	1.84
39	67621	1.97
40	67488	2.12
41	67345	2.30
42	67190	2.49
43	67023	2.67
44	66844	2.85
45	66653	3.06
46	66449	3.27
47	66232	3.50
48	66000	3.76
49	65752	4.02
50	65488	4.33
51	65204	4.67
52	64899	5.05
53	64571	5.49
54	64217	5.96
55	63834	6.46
56	63422	6.99
57	62979	7.54
58	62504	8.06
59	62000	8.65
60	61464	9.32
61	60891	10.11
62	60275	11.04
63	59610	12.20
64	58883	13.55
65	58085	15.01
66	57213	16.58
67	56264	18.21
68	55239	19.86
69	54142	21.65
70	52970	23.69
71	51715	26.19
72	50361	28.98
73	48902	32.47
74	47314	36.50
75	45587	41.02
76	43717	45.94
77	41709	51.16
78	39575	56.73
79	37330	62.78
80	34986	69.53
81	32553	77.24
82	30039	86.13
83	27452	96.33
84	24808	107.59
85	22139	119.91
86	19484	132.99
87	16893	146.95
88	14411	161.59
89	12082	177.21
90	9941	193.74
91	8015	211.49
92	6320	*231.05
93	4860	*253.44

Age	l_x	$1000q_x$
94	3628	*280.66
95	2610	*318.37
96	1779	*376.21
97	1110	*475.72
98	582	*656.09
99	200	1000.00

1980 CET-NF NON-SMOKER TABLE 24

Age	l_x	$1000q_x$
15	974349	1.69
16	972702	1.74
17	971009	1.79
18	969271	1.82
19	967507	1.87
20	965698	1.90
21	963863	1.89
22	962041	1.91
23	960204	1.91
24	958370	1.93
25	956520	1.92
26	954683	1.94
27	952831	1.95
28	950973	1.98
29	949090	2.00
30	947192	2.03
31	945269	2.07
32	943312	2.10
33	941331	2.13
34	939326	2.20
35	937259	2.26
36	935141	2.36
37	932934	2.46
38	930639	2.59
39	928229	2.72
40	925704	2.87
41	923047	3.05
42	920232	3.24
43	917250	3.47
44	914067	3.71
45	910676	3.98
46	907052	4.25
47	903197	4.55
48	899087	4.89
49	894690	5.23
50	890011	5.63
51	885000	6.07
52	879628	6.57
53	873849	7.14
54	867610	7.75
55	860886	8.40
56	853655	9.09
57	845895	9.80
58	837605	10.48
59	828827	11.25
60	819503	12.12
61	809571	13.14
62	798933	14.35
63	787468	15.86
64	774979	17.62
65	761324	19.51
66	746471	21.55
67	730385	23.67
68	713097	25.82
69	694685	28.15

<u>Age</u>	<u>1_x</u>	<u>1000q_x</u>
70	675130	30.80
71	654336	34.05
72	632056	37.67
73	608246	42.21
74	582572	47.45
75	554929	53.33
76	525335	59.72
77	493962	66.51
78	461109	73.75
79	427102	81.61
80	392246	90.39
81	356791	100.41
82	320966	111.97
83	285027	125.23
84	249333	139.87
85	214459	155.88
86	181029	172.89
87	149731	191.04
88	121126	210.07
89	95681	230.37
90	73639	251.86
91	55092	274.94
92	39945	300.37
93	27947	329.47
94	18739	364.86
95	11902	413.88
96	6976	489.07
97	3564	618.44
98	1360	852.92
99	200	1000.00

<u>Age</u>	<u>Non- Smoker</u>	<u>Smoker</u>
43	3.52	5.36
44	3.76	5.77
45	4.02	6.21
46	4.29	6.67
47	4.59	7.14
48	4.90	7.64
49	5.25	8.20
50	5.64	8.80
51	6.07	9.44
52	6.57	10.17
53	7.11	10.97
54	7.67	11.79
55	8.27	12.64
56	8.87	13.47
57	9.45	14.25
58	10.04	15.02
59	10.70	15.83
60	11.48	16.81
61	12.44	18.03
62	13.64	19.60
63	15.11	21.52
64	16.76	23.65
65	18.54	25.90
66	20.38	28.18
67	22.27	30.39
68	24.22	32.63
69	26.39	35.06
70	28.94	37.93
71	32.05	41.57
72	35.85	46.03
73	40.42	51.34
74	45.67	57.38
75	51.53	63.99
76	57.88	71.01
77	64.68	78.31
78	72.03	86.09
79	80.18	94.52
80	89.45	103.97
81	100.11	114.70
82	112.40	126.89
83	126.26	140.97
84	141.53	156.23
85	158.05	172.45
86	175.71	189.48
87	194.47	207.16
88	214.34	225.58
89	235.50	244.73
90	258.09	265.95
91	282.65	288.81
92	310.09	314.16
93	342.36	343.93
94	383.80	383.80
95	443.33	443.33
96	538.04	538.04
97	698.41	698.41
98	967.15	967.15
99	1000.00	1000.00

Age nearest birthday CSO: Sum qx = 3259.34 Sum 1x = 4340089
 * Adjusted; see text CET: Sum qx = 7315.40 Sum 1x = 57404657

1980 CET-NG Nonsmoker Table 25

<u>Age</u>	<u>Non- Smoker</u>	<u>Smoker</u>
15	1.61	1.71
16	1.65	1.76
17	1.68	1.81
18	1.71	1.86
19	1.74	1.89
20	1.76	1.92
21	1.78	1.94
22	1.79	1.97
23	1.81	2.00
24	1.83	2.03
25	1.85	2.06
26	1.88	2.11
27	1.90	2.15
28	1.93	2.20
29	1.97	2.26
30	2.00	2.33
31	2.04	2.39
32	2.08	2.46
33	2.13	2.55
34	2.19	2.65
35	2.26	2.76
36	2.36	2.93
37	2.48	3.13
38	2.61	3.39
39	2.75	3.72
40	2.92	4.11
41	3.10	4.52
42	3.29	4.94

1980 CET-SG Smoker Table 26

<u>Age</u>	<u>Non- Smoker</u>	<u>Smoker</u>
15	1.61	1.71
16	1.65	1.76

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>	<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
17	1.68	1.81	82	112.40	126.89
18	1.71	1.86	83	126.26	140.97
19	1.74	1.89	84	141.53	156.23
20	1.76	1.92	85	158.05	172.45
21	1.78	1.94	86	175.71	189.48
22	1.79	1.97	87	194.47	207.16
23	1.81	2.00	88	214.34	225.58
24	1.83	2.03	89	235.50	244.73
25	1.85	2.06	90	258.09	265.95
26	1.88	2.11	91	282.65	288.81
27	1.90	2.15	92	310.09	314.16
28	1.93	2.20	93	342.36	343.93
29	1.97	2.26	94	383.80	383.80
30	2.00	2.33	95	443.33	443.33
31	2.04	2.39	96	538.04	538.04
32	2.08	2.46	97	698.41	698.41
33	2.13	2.55	98	967.15	967.15
34	2.19	2.65	99	1000.00	1000.00
35	2.26	2.76			
36	2.36	2.93			
37	2.48	3.13			
38	2.61	3.39			
39	2.75	3.72			
40	2.92	4.11			
41	3.10	4.52			
42	3.29	4.94			
43	3.52	5.36			
44	3.76	5.77			
45	4.02	6.21			
46	4.29	6.67			
47	4.59	7.14			
48	4.90	7.64			
49	5.25	8.20			
50	5.64	8.80			
51	6.07	9.44			
52	6.57	10.17			
53	7.11	10.97			
54	7.67	11.79			
55	8.27	12.64			
56	8.87	13.47			
57	9.45	14.25			
58	10.04	15.02			
59	10.70	15.83			
60	11.48	16.81			
61	12.44	18.03			
62	13.64	19.60			
63	15.11	21.52			
64	16.76	23.65			
65	18.54	25.90			
66	20.38	28.18			
67	22.27	30.39			
68	24.22	32.63			
69	26.39	35.06			
70	28.94	37.93			
71	32.05	41.57			
72	35.85	46.03			
73	40.42	51.34			
74	45.67	57.38			
75	51.53	63.99			
76	57.88	71.01			
77	64.68	78.31			
78	72.03	86.09			
79	80.18	94.52			
80	89.45	103.97			
81	100.11	114.70			

1980 CSO-NG Nonsmoker Table 27

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
15	0.84	0.94
16	0.88	0.99
17	0.92	1.04
18	0.95	1.09
19	0.98	1.13
20	1.01	1.16
21	1.02	1.18
22	1.04	1.18
23	1.05	1.23
24	1.08	1.27
25	1.09	1.29
26	1.12	1.34
27	1.14	1.38
28	1.17	1.42
29	1.20	1.48
30	1.24	1.55
31	1.27	1.61
32	1.31	1.68
33	1.35	1.75
34	1.42	1.86
35	1.47	1.94
36	1.56	2.09
37	1.67	2.28
38	1.79	2.49
39	1.93	2.73
40	2.08	3.00
41	2.26	3.33
42	2.44	3.64
43	2.62	3.96
44	2.80	4.28
45	2.99	4.61
46	3.19	4.95
47	3.41	5.31
48	3.65	5.68
49	3.90	6.08
50	4.19	6.54
51	4.50	7.00
52	4.85	7.52
53	5.26	8.13
54	5.68	8.75
55	6.13	9.40

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>	<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
56	6.59	10.05	30	1.24	1.55
57	7.05	10.67	31	1.27	1.61
58	7.49	11.25	32	1.31	1.68
59	7.96	11.85	33	1.35	1.75
60	8.51	12.51	34	1.42	1.86
61	9.16	13.36	35	1.47	1.94
62	9.98	14.39	36	1.56	2.09
63	11.01	15.78	37	1.67	2.28
64	12.23	17.33	38	1.79	2.49
65	13.55	19.07	39	1.93	2.73
66	14.97	20.79	40	2.08	3.00
67	16.41	22.58	41	2.26	3.33
68	17.86	24.20	42	2.44	3.64
69	19.41	26.02	43	2.62	3.96
70	21.20	27.95	44	2.80	4.28
71	23.34	30.45	45	2.99	4.61
72	25.99	33.55	46	3.19	4.95
73	29.22	37.33	47	3.41	5.31
74	33.02	41.74	48	3.65	5.68
75	37.32	46.64	49	3.90	6.08
76	42.04	51.92	50	4.19	6.54
77	47.11	57.46	51	4.50	7.00
78	52.53	63.23	52	4.85	7.52
79	58.45	69.41	53	5.26	8.13
80	65.12	76.26	54	5.68	8.75
81	72.76	84.00	55	6.13	9.40
82	81.59	92.84	56	6.59	10.05
83	91.76	102.87	57	7.05	10.67
84	103.03	114.65	58	7.49	11.25
85	115.38	126.42	59	7.96	11.85
86	128.58	139.79	60	8.51	12.51
87	142.71	152.67	61	9.16	13.36
88	157.61	167.23	62	9.98	14.39
89	173.51	181.07	63	11.01	15.78
90	190.39	197.01	64	12.23	17.33
91	208.58	214.00	65	13.55	19.07
92	228.60	232.54	66	14.97	20.79
93	251.40	253.55	67	16.41	22.58
94	279.31	279.31	68	17.86	24.20
95	317.32	317.32	69	19.41	26.02
96	375.74	375.74	70	21.20	27.95
97	474.97	474.97	71	23.34	30.45
98	655.85	655.85	72	25.99	33.55
99	1000.00	1000.00	73	29.22	37.33
			74	33.02	41.74
			75	37.32	46.64
			76	42.04	51.92
			77	47.11	57.46
			78	52.53	63.23
			79	58.45	69.41
			80	65.12	76.26
			81	72.76	84.00
			82	81.59	92.84
			83	91.76	102.87
			84	103.03	114.65
			85	115.38	126.42
			86	128.58	139.79
			87	142.71	152.67
			88	157.61	167.23
			89	173.51	181.07
			90	190.39	197.01
			91	208.58	214.00
			92	228.60	232.54
			93	251.40	253.55
			94	279.31	279.31

1980 CSO-SG Smoker Table 28

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
15	0.84	0.94
16	0.88	0.99
17	0.92	1.04
18	0.95	1.09
19	0.98	1.13
20	1.01	1.16
21	1.02	1.18
22	1.04	1.18
23	1.05	1.23
24	1.08	1.27
25	1.09	1.29
26	1.12	1.34
27	1.14	1.38
28	1.17	1.42
29	1.20	1.48

<u>Age</u>	<u>Non-Smoker</u>	<u>Smoker</u>
95	317.32	317.32
96	375.74	375.74
97	474.97	474.97
98	655.85	655.85
99	1000.00	1000.00

SUBCHAPTER 23. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT COVERAGE

11:4-23.1 Purpose

This subchapter provides for the reasonable standardization of coverage and the simplification of terms and benefits of Medicare supplement policies; facilitates comparison of such policies in order to increase public understanding; eliminates provisions which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and provides for full disclosure in the sale of health care service benefits and insurance to persons eligible for Medicare.

Amended by R.1991 d.345, effective July 1, 1991.
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted “, contracts and certificates issued on a group basis”, “public understanding and”, “and contracts”, “contained in such policies”, “and service corporation coverages”; added “in order to increase public understanding”, “of such policies”, “care service benefits and”.
Amended by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).
Deleted “by reason of age.”

11:4-23.2 Applicability and scope

(a) This subchapter shall apply to:

1. All Medicare supplement policies, as defined by this subchapter, delivered or issued for delivery in this State;
2. All certificates, as defined by this subchapter, issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State.

(b) This subchapter shall apply to all carriers, as defined in this subchapter, delivering or issuing for delivery Medicare supplement policies in this State, or delivering or issuing for delivery certificates in this State, which certificates were issued under a group Medicare supplement policy.

Amended by R.1991 d.345, effective July 1, 1991.
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Added “in N.J.A.C. 11:4-23.8 and 23.9” in (a).
Deleted “group”, “and individual and group subscriber Medicare Supplement contracts”; added “as defined by this subchapter”; changed “the effective date” to “July 1, 1991” in (a)1.
Deleted “Supplement”, “or subscriber contracts”, “policies or contracts”; added “as defined by this subchapter”, “supplement”, “certificates”, “on or after July 1, 1991” in (a)2.

Deleted (b).
Amended by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).
Certificates delivered or issued for delivery in New Jersey added.

11:4-23.3 Definitions

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

“Aggregate loss ratio” means the ratio of the accumulated value of past benefits (from the original effective date of the form to the date as of which the ratio is determined) and the present value of future benefits to the accumulated value of past premiums (from the original effective date of the form to the date as of which the ratio is determined) and the present value of future premiums. Benefits shall not be increased nor premiums reduced by actual or anticipated dividends, and interest shall be included in the accumulated and present values on the same basis as in the present values of the anticipated loss ratio.

“Anticipated loss ratio” means the ratio of the present value of the expected benefits, not including dividends, to the present value of the expected premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. For purposes of this ratio, the present values must incorporate realistic rates of interest which are determined before Federal taxes but after investment expenses. Benefits and premiums shall be discounted from the year of payment, with reasonable assumptions as to time of payment within the year.

“Applicant” means:

1. In the case of a group policy, the proposed certificate holder;
2. In the case of an individual policy, the person who seeks to contract for coverage.

“Carrier” means any person who contracts to provide health services, reimburse the cost of health services in whole or in part, or provide an indemnity in the event that health services are used, in return for a prepaid or postpaid premium or other consideration, including insurance companies, fraternal benefit societies, hospital, medical and health service corporations, health maintenance organizations and such other similar entities.

“Certificate” means any certificate or other document which sets forth or summarizes the essential features of the coverage issued under a group policy, which certificate or other document has been delivered or issued for delivery in this State.

“Certificate form” means the form on which a certificate is delivered or issued for delivery by a carrier.

“Coverage” means:

1. Any arrangement whereby a carrier agrees to indemnify or reimburse an individual or group member for some portion or part of the health related costs incurred by that individual or member, subject to the terms of the written agreement and law; and

2. Any arrangement whereby a carrier agrees to provide direct or indirect health care services to the individual or group member, subject to the terms of the written agreement and law.

“Insured” means any applicant provided coverage by a carrier.

“Medicare supplement policy” means a group or individual policy which is advertised, marketed or designed primarily as, or is otherwise held out to be a supplement to reimbursements under Medicare, other than a policy issued pursuant to a contract under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), or a contract or policy issued under a demonstration project pursuant to amendments to the Federal Social Security Act. This term does not include a policy or certificate of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or combination thereof, of the labor organization.

“Policy” shall mean any policy, contract, certificate or other document which sets forth or summarizes the essential features of the coverage issued to an individual or group by a carrier, for the purpose of providing Medicare supplement coverage, including any such policy issued pursuant to a conversion privilege to an individual 65 years of age or older, except as otherwise provided in this subchapter or Federal law.

“Policy form” means the form on which a policy is delivered or issued for delivery by a carrier.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted “Medicare supplement” in “applicant” 1.

Deleted “Medicare supplement subscriber contract”, “hospital or medical service benefits,”; added “policy”, “coverage” in “applicant” 2.

Deleted “applicant” 3.

Deleted “:1. Any”, “Medicare Supplement”, “policy”; added “or other document which sets forth or summarizes the essential features of the coverage”, “certificate or other document” in “Certificate” 1.

Deleted “Certificate” 2.

Added “Coverage”.

Deleted “.1.A”, “accident and sickness insurance”, “.i.A”; deleted ii and iii in “Medicare supplement policy”.

Deleted “Medicare supplement policy” 2.

Added “Policy”.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Added definitions for aggregate loss ratio, anticipated loss ratio, carrier, certificate form and policy form; deleted definition of, and references to, insurer.

11:4-23.4 Policy definitions and terms

(a) No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

1. “Accident,” “accidental injury,” or “accidental means” shall be defined to employ “result” language and shall not include words which establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization.

i. “Injury” shall not be defined more restrictively than as a bodily injury sustained by the covered person as a result of an accident, which injury is the direct cause of the loss, independent of disease, bodily infirmity or any other cause, and which occurs while coverage is in force.

ii. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers’ compensation, employer’s liability or similar law, mandatory motor vehicle no-fault plan, unless prohibited by law.

2. “Benefit period” or “Medicare benefit period” shall not be defined more restrictively than as defined in the Medicare program.

3. “Convalescent nursing home,” “extended care facility,” or “skilled nursing facility” shall not be defined more restrictively than as defined by the Medicare program.

4. “Health care expenses” means expenses of health maintenance organizations which expenses are associated with the delivery of health care services and are analogous to incurred losses of insurers. Such expenses shall not include the following costs:

- i. Home office and overhead costs;
- ii. Advertising costs;
- iii. Commissions and other acquisition costs;
- iv. Taxes;
- v. Capital costs;
- vi. Administrative costs; and
- vii. Claims processing costs.

5. “Hospital” may be defined in relation to its status, facilities, and available services or to reflect accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined by the Medicare program.

6. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Laws 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

7. "Medicare eligible expense" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

8. "Physician" shall not be defined more restrictively than as defined by the Medicare program.

9. "Preexisting condition" shall not be defined more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

10. "Sickness" shall not be defined more restrictively than a sickness or disease which causes loss commencing while the insurance or coverage is in force and which is not excluded under a preexisting condition limitation. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

11. "Totally disabled" shall not be defined more restrictively than as:

- i. An injury or sickness that continuously confines an individual in a hospital or skilled nursing facility; or
- ii. A continuous disability resulting from an injury or sickness not requiring confinement of an individual in a hospital or skilled nursing facility, but which a physician certifies as preventing that individual from engaging in the normal activities of a person of like age and sex in good health.

Amended by R.1991 d.345, effective July 1, 1991.
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted "group insurance", "or individual or group subscriber contract", "Supplement", "or subscriber contract" in (a).

Deleted "the definition of injury", "an accidental", "insurance or service corporation"; added "Injury", "defined", "as a result of an accident", "injury" in (a)1i.

Deleted "or injuries occurring while the covered person is engaged in any activity pertaining to any trade, or business, employment, or occupation for wage or profit" in (a)1ii.

Deleted "or hospital or medical service corporations", "may", "as are applicable to Medicare claims"; added "shall", "as are applicable to Medicare claims" in (a)1ii6.

Deleted "or hospital or medical service corporation" in (a)1ii8 and 9.
Added (a)1ii12.

Amended by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Added definition for health care expenses and references to Medicare standards.

11:4-23.5 Policy provisions

(a) No policy or certificate shall be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy if such policy or certificate contains limitations or exclusions that are more restrictive than those of Medicare, except with respect to preexisting condition limitations.

(b) No Medicare supplement policy or certificate shall provide benefits which duplicate benefits provided by Medicare.

(c) No Medicare supplement policy or certificate shall use waiver endorsements or riders to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted "Medicare Supplement", "may", "such policy"; added "shall", "as a Medicare supplement policy", "it" in (a).

Added "outside the United States" in (a)10.

Changed "Supplement" to "supplement" and "may" to "shall" in (b), (c) and (d); added "endorsements or riders" to (d).

Added (e).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule amended to conform to Medicare standards.

11:4-23.6 General minimum benefit standards

(a) No policy or certificate shall be advertised, solicited, or issued for delivery in this State as a Medicare supplement policy if it does not meet the minimum standards contained in this section.

(b) The following general standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this subchapter.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred as a result of a preexisting condition after six months from the effective date of coverage, nor shall a preexisting condition be defined more restrictively than as set forth at N.J.A.C. 11:4-23.4(a)9.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amounts and copayment percentage factors, if any, in response to which premiums may be correspondingly modified subject to the requirements of N.J.A.C. 11:4-23.11.

4. A Medicare supplement policy or certificate shall not:

i. Provide for termination of coverage of an eligible spouse because of termination of coverage of the insured other than for nonpayment of premium; or

ii. Provide for termination of a covered persons' coverage by the carrier solely on the grounds of age or deterioration of health.

5. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the covered person limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

6. Existing Medicare supplement policies and certificates shall be appropriately amended or endorsed to eliminate benefit duplications with Medicare which are caused by Medicare benefit changes. Any riders or endorsements shall specify the benefits deleted, or shall otherwise result in a clear description of the Medicare supplement benefits provided by the policy. Such riders or endorsements shall be submitted for filing by the Commissioner.

(c) A carrier shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation. With respect to terminations of group policies, or membership in a group, the following standards shall apply:

1. If a group policyholder terminates the group Medicare supplement policy without replacing that policy as provided in (c)3 below, the carrier shall offer individuals covered under group policies at least the following two coverage choices:

i. An individual guaranteed renewable Medicare supplement policy which provides for continuation of the benefits contained in the group policy; and

ii. An individual Medicare supplement policy which provides only such benefits as otherwise are required to meet N.J.A.C. 11:4-23.8.

2. If membership in a group is terminated, the carrier shall:

i. Offer the individual whose membership is terminated such conversion opportunities as are described in (c)1 above; or

ii. Offer the individual whose membership is terminated continuation of coverage under the group policy, but only at the option of the group policyholder.

3. If a group policyholder replaces one group Medicare supplement policy by another group Medicare supplement policy, the succeeding carrier shall offer coverage to all persons who were covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusions for preexisting conditions that would have been covered under the group policy which was replaced.

Amended by R.1988 d.587, effective December 19, 1988 (operative January 1, 1989).

See: 20 N.J.R. 2510(a), 20 N.J.R. 3155(c).

Added (b)6.-10.; (c)1 and renumbered (c)1.-4. as i.-iv.; added (c)2. Amended by R.1991 d.121, effective March 4, 1991.

See: 22 N.J.R. 771(a), 23 N.J.R. 690(c).

In (b)7: revised internal references to chapter.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted "group insurance"; "For individual or group subscriber contract may"; "which"; added "shall"; "if it" in (a).

Added "nor shall a preexisting condition be defined more restrictively than as set forth at N.J.A.C. 11:4-23.4(a)11." in (b) with stylistic change.

Added "in response to which premiums may be correspondingly modified subject to the requirements of N.J.A.C. 11:4-23.8" in (b)3.

Deleted ", or subscriber" in (b)4i.

Deleted "For hospital or medical service corporation" in (b)4ii.

Deleted (b)6, 7, 9, 10.

Recodified existing (b)8 as 6; deleted "commissioner for filing with 45 days after the effective dates of Medicare benefit changes".

Added (c) and (d).

Recodified existing (c) as (e); recodified existing (c)1i, ii, iii, iv as (e)2, 3, 4, 6.

Deleted "For policies issued prior to January 1, 1989;"; added "coverage for either all or none of the Medicare Part A in-patient hospital deductible amount;" in recodified (e)1.

Added (e)5, 7.

Deleted "of \$200.00 of such expenses and to a maximum calendar year benefit of at least \$5,000.;" added "regardless of hospital confinement", "amount equal to the Medicare Part B" in recodified (e)6.

Deleted (c)2.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

General standards for policies and certificates delineated, references to insurer changed to "carrier."

11:4-23.7 Minimum benefits for policies and certificates delivered or issued for delivery prior to January 4, 1993

(a) All policies delivered or issued for delivery in this State prior to January 4, 1993, and all certificates delivered or issued for delivery in this State on or after July 15, 1991 but prior to January 4, 1993 as a Medicare supplement policy or certificate, shall meet the minimum standards set forth at N.J.A.C. 11:4-23.6 in addition to the minimum standards set forth below. The standards of N.J.A.C. 11:4-23.6 and those below are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(b) Benefit conversion requirements for the transition of policy compliance between the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) and the Medicare Catastrophic Coverage Repeal Act of 1989 (P.L. 101-234) are as follows:

1. Effective January 1, 1990, no Medicare supplement policy in force in this State shall contain benefits provided by Medicare.

2. Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

3. For Medicare supplement policies subject to the minimum standards adopted by this State pursuant to the Medicare Catastrophic Coverage Act of 1988, and all policies and certificates delivered or issued for delivery on or after April 16, 1990 but prior to January 4, 1993, the minimum benefit standards for Medicare supplement policies are:

i. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

ii. Coverage of the Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

iii. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

iv. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

v. Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations or already paid for under Part B;

vi. Coverage of Part B Medicare eligible expenses to the extent not covered by Medicare regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible;

vii. Coverage under Medicare Part B for the reasonable cost of the first three pints (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(c) Medicare supplement policies shall be guaranteed renewable.

New Rule, R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on Standards for claims payment recodified to 23.10.

11:4-23.8 Minimum benefit standards for policies and certificates delivered or issued for delivery on or after January 4, 1993

(a) No policy or certificate shall be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy on or after January 4, 1993 unless it complies with the standards of N.J.A.C. 11:4-23.6 and the benefit standards set forth below.

(b) Medicare supplement policies shall be guaranteed renewable.

(c) A Medicare supplement policy or certificate shall provide that benefits and premiums shall be suspended for a period of up to 24 months upon the request of a policyholder or certificateholder who has applied for and been determined entitled to medical assistance under Title XIX of the Social Security Act (that is, Medicaid), during or at the end of which period of suspension, the policy or certificate shall be reinstated automatically upon notice to the carrier by the policyholder or certificateholder.

1. Benefits and premiums shall not be suspended unless the policyholder or certificateholder provides the carrier notice of entitlement to medical assistance under Title XIX of the Social Security Act within 90 days following the date the policyholder or certificateholder was determined to be so entitled.

2. Upon receipt of a notice of entitlement to medical assistance, the carrier shall return to the policyholder that portion of the premiums already paid which are attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

3. Upon loss of entitlement to medical assistance within the period of suspension, or upon the date following the final day of the period of suspension, the policy or certificate shall be automatically reinstated, effective as of the date of termination of entitlement, or effective as of the day following the final day of the period of suspension, if within 90 days following the date of entitlement termination or the final day of the suspension period, the policyholder or certificateholder provides notice to the carrier for reinstatement of the policy or certificate, and pays the premium required by the carrier, which premium shall be for a period of coverage not exceeding six months, inclusive of the 90 day notice period, but exclusive of any period during which the policyholder or certificateholder was entitled to medical assistance pursuant to Medicaid.

4. The coverage under the policy or certificate reinstated:

i. Shall not be subject to any waiting period with respect to treatment of preexisting conditions;

ii. Shall be substantially equivalent to coverage which was in effect prior to the date of suspension of the policy or certificate; and

iii. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(d) All carriers delivering or issuing for delivery in this State Medicare supplement policies or certificates of group Medicare supplement policies shall offer to all applicants a

policy or certificate providing only the core benefits defined at (g) below. A policy or certificate providing only core benefits shall be designated as standardized Medicare supplement benefit plan A.

(e) Carriers may offer to all applicants policies or certificates providing the core benefits and additional benefits defined at (g) below. Only those additional benefits defined at (g) below may be included in Medicare supplement policies or certificates delivered or issued for delivery in this State. Policies or certificates providing additional benefits shall be structured and designated as follows:

1. Standardized Medicare supplement benefit plan B shall provide:

- i. The Core Benefit; and
- ii. The Medicare Part A Deductible benefit.

2. Standardized Medicare supplement benefit plan C shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medicare Part B Deductible benefit; and
- v. The Medically Necessary Emergency Care in a Foreign Country benefit.

3. Standardized Medicare supplement benefit plan D shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- v. The At-Home Recovery Benefit.

4. Standardized Medicare supplement benefit Plan E shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- v. The Preventive Medical Care benefit.

5. Standardized Medicare supplement benefit Plan F shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;

- iv. The Medicare Part B Deductible benefit;
- v. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit; and

vi. The Medically Necessary Emergency Care in a Foreign Country benefit.

6. Standardized Medicare supplement benefit plan G shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Eighty Percent (80%) of the Medicare Part B Excess Charges benefit;
- v. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- vi. The At-Home Recovery Benefit.

7. Standardized Medicare supplement benefit plan H shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Basic Outpatient Prescription Drug Benefit; and
- v. The Medically Necessary Emergency Care in a Foreign Country benefit.

8. Standardized Medicare supplement benefit plan I shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit;
- v. The Basic Outpatient Prescription Drug Benefit; and
- vi. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- vii. The At-Home Recovery Benefit.

9. Standardized Medicare supplement benefit plan J shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medicare Part B Deductible benefit;

- v. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit;
- vi. The Extended Outpatient Prescription Drug Benefit;
- vii. The Medically Necessary Emergency Care in a Foreign Country benefit;
- viii. The Preventive Medical Care benefit; and
- ix. The At-Home Recovery Benefit.

(f) No groupings, packages or combinations of Medicare supplement benefits shall be offered which differ from the standardized Medicare supplement benefit plans specified in (d) and (e) above, except as an Innovative Benefit which may be approved by the Commissioner. Benefit plans shall be uniform in structure, language, designation and format to the standardized Medicare supplement benefit plans A, B, C, D, E, F, G, H, I and J as set forth in (d) and (e) above. For purposes of this section, "structure," "language," and "format" means style, arrangement and overall content of a benefit.

(g) The following terms and phrases, as used in this section, shall have the following meanings:

1. "At-Home Recovery Benefit" means coverage for services to provide short term, at-home assistance with activities of daily living for persons recovering from an illness, injury or surgery. At-home recovery services shall be services which are designed primarily to assist with activities of daily living.

i. The insured's attending physician shall certify that the specific type and frequency of at-home recovery services prescribed are necessary due to a condition for which a home care plan of treatment was approved by Medicare.

ii. Coverage shall be limited to:

(1) The number and type of at-home recovery visits certified as necessary by the insured's attending physician, received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit, the total number of which shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(2) Care furnished on a visiting basis in the insured's home by a care provider as defined at (g)1v below for up to seven visits in any one week; and

(3) Actual charges up to \$40.00 per visit to a maximum per calendar year benefit of \$1,600.

iii. Coverage shall be excluded for home care visits reimbursed by Medicare or other government programs and for care provided by family members, unpaid vol-

unteers, or providers who do not otherwise meet the definition of a care provider, to the extent Medicare would exclude coverage for care provided by such individuals.

iv. Activities of daily living shall include, but not be limited to, bathing, dressing, personal hygiene, eating, ambulating, assistance with drugs that are normally self-administered, and changing of bandages or other dressings.

v. A care provider shall be a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or a licensed nurses registry.

vi. Any place used by the insured as a place of residence shall be the insured's home, provided that such place would qualify as a residence for home health care services under Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

vii. An at-home recovery visit shall be that period of a visit required to provide at-home recovery care. The duration of any such visit shall not be limited, but each consecutive four hours in a 24 hour period of services provided by a care provider shall constitute one visit for purposes of this section.

2. "Basic Outpatient Prescription Drug Benefit" means coverage for 50 percent of outpatient prescription drug charges to the extent not covered by Medicare, subject to a \$250.00 calendar year deductible and a maximum per calendar year benefit per insured of \$1,250.

3. "Core Benefit" means coverage of:

i. Medicare Part A eligible expenses for hospitalization from the 61st day through the 90th day in any Medicare benefit period, to the extent not covered by Medicare;

ii. Medicare Part A eligible expenses for hospitalization for each Medicare lifetime inpatient reserve day used, to the extent not covered by Medicare;

iii. Medicare Part A eligible expenses for hospitalization upon exhaustion of Medicare hospital inpatient coverage, including lifetime reserve days, up to a maximum lifetime benefit of 365 days, to be paid at the Diagnostic Related Group (DRG) outlier per diem, or other appropriate standard of payment as set forth by the Health Care Financing Administration of the United States Department of Health and Human Services for Medicare payments when DRG day outlier payment is not appropriate;

iv. The reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by Federal regulations) under Medi-

care Parts A and B, unless replaced in accordance with Federal regulation; and

v. The coinsurance amount of Medicare Part B eligible expenses, regardless of hospital confinement, subject to the Medicare Part B deductible.

4. "Eighty Percent (80%) of the Medicare Part B Excess Charges" means coverage for 80 percent of the difference between the Medicare-approved Part B charge and the actual Medicare Part B charge billed, up to but not exceeding any charge limitation established by the Medicare program or this State's law, if any.

5. "Extended Outpatient Prescription Drug Benefit" means coverage for 50 percent of outpatient prescription drug charges to the extent not covered by Medicare, subject to a \$250.00 deductible per calendar year, and a maximum per calendar year per insured benefit of \$3,000.

6. "Innovative Benefits" means benefits that are in addition to the benefits specified for standardized Medicare supplement benefit plans A, B, C, D, E, F, G, H, I and J, that are appropriate to Medicare supplement insurance and do not duplicate any benefit provided by Medicare, and that are otherwise unavailable, cost effective, and offered in a manner consistent with simplification of Medicare supplement policies. No carrier shall include an Innovative Benefit in a policy or certificate offered for delivery in this State without the prior approval of the Commissioner.

7. "Medically Necessary Emergency Care in a Foreign Country" means coverage of 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if received in the United States, and which care began during the first 60 consecutive days of each trip outside the United States, to the extent billed charges are not covered by Medicare, and subject to a calendar year deductible of \$250.00 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

8. "Medicare Part A Deductible" means coverage of all of the Medicare Part A inpatient hospital deductible amount per benefit period.

9. "Medicare Part B Deductible" means coverage of all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

10. "One Hundred Percent (100%) of the Medicare Part B Excess Charges" means coverage for all of the difference between the Medicare Part B approved charge and the actual Medicare Part B billed charge, up to but not exceeding any charge limitation established by the Medicare program or this State's law, if any.

11. "Preventive Medical Care Benefit" means coverage of the following services not otherwise covered by Medicare in the calendar year for the actual charges up to 100 percent of the Medicare-approved amount for each service (as if Medicare were to cover the service as identified in the American Medical Association Current Procedural Terminology Codes), subject to a maximum benefit of \$120.00 per calendar year:

i. An annual clinical preventive medical history and physical examination that shall include patient education to address preventive health care measures and any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(1) Fecal occult blood test and/or digital rectal examination;

(2) Mammogram;

(3) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria;

(4) Pure tone (air only) hearing screening test administered or ordered by a physician;

(5) Serum cholesterol screening (every five years);

(6) Thyroid function test; and

(7) Diabetes screening;

ii. Influenza vaccine administered at any appropriate time during a calendar year;

iii. Tetanus and diphtheria booster (every 10 years); and

iv. Other tests or preventive measures determined appropriate by the attending physician.

12. "Skilled Nursing Facility Care" means coverage for the actual billed charges up to the Medicare coinsurance amount from the 21st day through the 100th day in a Medicare benefit period, for posthospital skilled nursing facility care eligible under Medicare Part A.

New Rule, R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on loss ratio standards recodified to 23.11; new rule added on minimum benefit standards for policies and certificates delivered or issued for delivery on or after the effective date of this subchapter.

11:4-23.9 Open Enrollment

(a) Carriers shall not deny or condition the effectiveness or issuance, nor discriminate in the pricing of Medicare supplement policies or certificates based on the health status, claims experience, receipt of health care by, or medical condition of an applicant if the application is submitted for Medicare supplement coverage during the six month period beginning with the first month in which the applicant (who is 65 years of age or older) first enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate shall be made available to all applicants who qualify under this section without regard to age.

(b) Nothing in (a) above shall be construed to prohibit or limit a carrier's use of permissible preexisting condition exclusion provisions in any Medicare supplement policy or certificate as set forth in this subchapter.

Amended by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on filing requirements recodified to 23.12; new rule added on open enrollment.

11:4-23.10 Standards for claims payment

(a) Every carrier providing Medicare supplement policies and certificates shall comply with Section 1882(c)(3) of the Social Security Act as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) by:

1. Acceptance of notice from a Medicare-Carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits under the Medicare supplement policy or certificate as sufficient claim notice without requiring other or additional claims forms to be submitted, and making a payment determination based on the information contained in the notice from the Medicare-Carrier;
2. Notification of the participating physician or supplier, and the beneficiary, of the payment determination, and making payment directly to the participating physician or supplier;
3. Providing each enrollee, at the time of enrollment, a card listing the policy name, policy number, and a mailing address to which notices from a Medicare-Carrier may be sent;
4. Payment of user fees for claim notices that are transmitted electronically or otherwise; and
5. Providing to the Secretary of Health and Human Services at least annually, a central mailing address to which all claims may be sent by the Medicare-Carrier.

(b) Compliance with the requirements set forth in (a) above shall be certified on the Medicare supplement experience reporting form.

(c) Payment of benefits for Medicare eligible expenses shall be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as are applicable to Medicare claims.

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Prior section 23.7 Loss Ratio Standards recodified to 23.8.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Standards for claims payment recodified from 23.7; requirements for compliance specified at (a)1 through 5.

11:4-23.11 Loss ratio standards, annual filing of premium rates and refund or credit calculation

(a) Medicare supplement policy forms or certificate forms shall be expected to return to policyholders and certificateholders in the form of aggregate benefits under the policy or certificate (exclusive of any anticipated refund or credit), for the entire period for which rates are computed to provide coverage, calculated on the basis of paid claims experience (or paid health care expenses for coverage provided by a health maintenance organization on a service rather than reimbursement basis) and written premiums for such period and with adjustment for interest to reflect the timing of payments:

1. At least 75 percent of the aggregate amount of premiums or subscription charges collected in the case of group policies and policies issued as conversions from group policies.
2. At least 65 percent of the aggregate amount of premiums or subscription charges collected in the case of individual policies.

(b) Each carrier shall include with the initial submission of rates for a new Medicare supplement policy an actuarial memorandum which includes the following:

1. The number of years for which the policy is expected to be delivered or issued for delivery in this State, and the number of policies expected to be delivered or issued for delivery for each form in each such year;
2. The anticipated loss ratio calculated over the life of the policy form, with separate disclosures of the present value of future paid benefits and the present value of future paid or written premiums utilized in the calculation of the anticipated loss ratio, where any statutorily required additional actuarial active life reserve is neither reflected in the future benefits nor the future premiums in the calculation;
3. The future benefits on both a paid and incurred basis and the future premiums on both a written and earned basis for each of the years recognized in the calculation of the anticipated loss ratio, where neither the future benefits nor the future premiums include, or are adjusted for, any statutorily required additional actuarial active life reserve;

4. The expected incurred/earned loss ratio for each of the years recognized in the calculation of the anticipated loss ratio, wherein:

- i. The expected incurred claims shall equal expected paid claims adjusted for changes in the expected claim liabilities and claim reserves and in any expected statutorily required additional actuarial active life reserve for each such year; and
- ii. The expected earned premiums shall equal premiums expected to be received adjusted for any changes in expected advance premiums and in expected

unearned premium reserves for each such year, but changes in any expected statutorily required additional actuarial active life reserves shall not be included in the adjustment of premiums expected to be received;

5. The realistic assumptions used in the calculation of the loss ratios for each benefit provision wherein the premiums are determined separately including the following:

i. The annual claim costs (ultimate) by attained age and sex;

ii. The select and/or antiselect morbidity factors by policy duration (year) by issue age and sex;

iii. The lapse and mortality rates, or total termination rates, by policy duration by issue age and sex, and any skewing of those rates occurring within a policy year resulting from modal premium payments;

iv. The secular trend factors by policy duration by issue age and sex, which secular trend factors, when used in the calculation of the anticipated loss ratio, shall not be applied for a period greater than the number of years for which trending is reflected in the calculation of premiums;

v. The interest rates by policy duration, which rates shall equal an insurer's recent, current and future expected new investment return rates (after investment expenses, but before Federal income taxes);

vi. Expenses by policy duration, including commission, override and bonus rates, other marketing expense rates, other maintenance expenses rates, any new-market expense rates, other acquisition expense rates, and the explicit profit margin or risk charge, provided on a per policy issue, per policy in force, per dollar of claim, per dollar of premium, and any other applicable bases;

vii. The distribution of expected policy issues by policy and rider benefits by issue age and sex;

viii. The percentage of policies expected to be issued with extra premiums for any physical, mental or medical conditions which result in substandard morbidity; and

ix. A summary statement of the underwriting standards (for example: short form medical and risk questionnaire, long form medical and risk questionnaire, medical examination), the marketing distribution system, and the market for the policy form (that is, the segment(s) of the general public to which the form will be marketed: middle income based on predetermined ZIP code selections for example);

6. The cell and cell weights, when a model office is used in the calculation of the anticipated loss ratio;

7. A demonstration evidencing that unfair pricing discrimination is not utilized by or incorporated within the policy form's premium table or structure.

i. The demonstration shall show that the recognition or nonrecognition or the homogenization of the elements of any insurance construct will not result in an anticipated loss ratio which would differ by more than 10 percent from the anticipated loss ratio of any element of the construct if the elements of the construct were not recognized or separately recognized, as the case may be.

ii. For the purpose of this paragraph, construct shall mean the risk variables which significantly affect the cost of the coverage. For example, age could be a construct wherein its elements would be age 65, age 66, age 67 and so forth. (Of particular concern are anticipated loss ratios by issue age or issue age groupings.); and

8. A certification signed by an actuary who must be a member of the Society of Actuaries or Casualty Actuarial Society, stating that the assumptions are appropriate to the policy form, reasonably represent the expected experience for the policy form and fully disclose the basis of the calculation of the anticipated loss ratio.

(c) Every carrier shall submit annually for filing by the Commissioner its rates. Supporting documentation, including ratios of incurred losses to earned premiums by policy duration shall be submitted annually with the rates. Any revision of rates is subject to the requirements of (d) below. The supporting documentation shall demonstrate, using reasonable assumptions, that the anticipated and aggregate loss ratio are at least as great as the originally anticipated loss ratio. Such demonstration shall exclude active life reserves.

(d) Carriers shall submit for filing by the Commissioner in accordance with N.J.A.C. 11:4-23.12 all rate revisions. No carrier shall implement any rate revision until such rate revision has been filed. Submission of rate revisions for filing shall demonstrate that both the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage and the aggregate loss ratio are at least as great as the originally anticipated loss ratio.

1. Prior to the effective date of enhancements in Medicare benefits, carriers shall:

i. Submit for filing appropriate premium adjustments required to produce loss ratios commensurate with the loss ratios anticipated for the current premium for the applicable policies or certificates, with accompanying documentation sufficient to justify the adjustment, in the opinion of the Commissioner; and

ii. Make such premium adjustments as are necessary to produce an expected loss ratio for a policy or certificate in accordance with the appropriate loss ratio standards of (a) above, and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the carrier for such policies and certificates. No premium adjustment which would modify the loss ratio experience under the policy, other than the adjustments described herein, shall be made at any time other than upon the policy renewal or anniversary date.

2. Every carrier shall submit for filing by the Commissioner a rate reduction whenever the expected aggregate loss ratio reported for a policy or certificate is less than the anticipated loss ratio for that policy or certificate, and the requirements of (c) above may not be met.

3. When a rate adjustment is requested pursuant to a change in the policy or certificate necessary to eliminate benefit duplication with Medicare, the submission for a rate change shall include any riders, endorsements, policy and certificate forms needed to accomplish the Medicare supplement coverage modification necessary to eliminate benefit duplications with Medicare. All such forms shall result in a clear description of the Medicare supplement benefits provided by the policy.

4. If a carrier does not make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the appropriate loss ratio.

(e) Carriers shall submit for filing with the Commissioner annually on or before May 31 reports in accordance with the reporting form contained in the Appendix to subchapters 16 and 23 of this chapter, Exhibit F, completed for each type in a standard Medicare supplement benefit plan.

1. If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), a refund or credit calculation shall be required.

i. The refund calculation shall be done on a State-wide basis for each type in a standard Medicare supplement benefit plan.

ii. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

2. A refund or credit shall be made by carriers whenever the benchmark loss ratio exceeds the adjusted experience loss ratio, and the amount to be refunded or credited exceeds a de minimis level.

i. A refund or credit against premiums due shall be made no later than September 30 following the experience year upon which the refund or credit is based.

ii. Refunds and credits shall include interest accruing from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of the United States Department of Health and Human Services, which in no event shall be less than the average rate of interest for 13-week Treasury notes.

(f) The Commissioner may conduct a public hearing, in his or her discretion, to gather information regarding a request by a carrier for an increase in a rate for a policy or certificate form, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard of (a) above. The determina-

tion of compliance shall be made without consideration of any refund or credit for such reporting period. Public notices of the hearing shall be in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

(g) For purposes of complying with (c) and (d) above, premiums and claims shall refer to premiums and claims for insured residents of this State under a specific policy form. However, if the experience is based on fewer than 1,000 life years of exposure for residents of this State, then the premiums and claims shall be a weighted average of the premiums and claims for this State and national experience, where the weighting factor applied to the State experience is the square root of the ratio of "a" to 1,000 ("a" being the number of the life years of exposure).

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section recodified from 23.7.

Added "and policies issued as conversions from group policies" in (a)1.

Substituted old text with new text in (b).

Added (b)1, 2; (c); (d); (e).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on required disclosure provisions recodified to 23.14; rule on loss ratio standards recodified from 23.8; standards for refunds and credit added.

11:4-23.12 Filing requirements for policies, certificates and premium rates

(a) No carrier shall deliver or issue for delivery in this State any Medicare supplement policy or certificate, any written application therefor, or any printed rider or endorsements to be applied thereto, unless the forms thereof have been submitted to and filed by the Commissioner.

1. At the expiration of 30 days after submission, the form shall be deemed filed unless affirmatively disapproved for filing by the Commissioner prior thereto.

2. If any such form is disapproved for filing by the Commissioner during the said 30-day period, it may not be delivered or issued for delivery unless and until such disapproval for filing is withdrawn. Such disapproval shall be subject to review in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

3. The Commissioner may extend the 30-day period no more than another 30 days if written notice is provided to the insurer before the expiration of the initial 30 day period, in which event all but this paragraph shall apply to the extended period.

4. Forms filed by or deemed filed by the Commissioner may subsequently be withdrawn from filing. Insurers shall have the right to a hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. An insurer may continue to deliver or issue for delivery such forms until a final decision in accordance with the withdrawal is rendered, following the request for

a hearing, or, if no hearing is requested, delivery or issuance for delivery of such forms may continue no later than 30 days following notice of the withdrawal of that form.

(b) Disapproval for filing, or withdrawals of approval of the filing of any form, must be stated in writing with the grounds therefor included in the statement, in accordance with the rules of this State.

(c) No carrier shall use or revise premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been submitted to and filed by the Commissioner in accordance with (a) and (b) above.

(d) The Commissioner shall not file, and carriers shall not submit for filing, more than one Medicare supplement policy or certificate form of each type for each standard Medicare supplement benefit plan, except as the Commissioner may otherwise approve in accordance with (d)2 below.

1. For the purposes of this subchapter, "type" shall mean an individual policy, and a group policy, and at such time as a Medicare Select program shall become effective in this State, an individual Medicare Select policy, and a group Medicare Select policy.

2. The Commissioner may approve carriers, individually, to offer up to four additional policy or certificate forms of the same type for the same standard Medicare supplement benefit plan. Such forms shall be subject to the filing requirements of this section. The four additional policy or certificate forms of the same type shall be limited to one additional form of the same type for:

- i. The inclusion of Innovative Benefits;
- ii. The addition of either a direct response or an agent marketing method;
- iii. The addition of either guaranteed issue or un-derwritten coverage; and
- iv. The offering of Medicare supplement coverage to persons eligible for Medicare by reason of disability.

(e) A carrier shall not discontinue offering any policy or certificate form filed by the Commissioner on or after the effective date of this subchapter unless such form has been withdrawn from filing pursuant to (a)4 above, or the carrier provides notice of discontinuance of offer to the Commissioner at least 30 days prior to such discontinuance, in writing.

1. Discontinuance subject to notice to the Commissioner shall include the following:

- i. Failure to actively offer for sale a policy or certificate form for more than 12 consecutive months;

ii. Sale or transfer of Medicare supplement policies or certificates to another carrier; and

iii. Revisions in the rating structure or methodology applicable to a Medicare supplement policy or certificate form which has not been otherwise submitted to and filed by the Commissioner in accordance with N.J.S.A. 11:4-23.11.

2. Carriers shall not submit for filing a new form for any Medicare supplement plan of the same type for which the carrier has discontinued issue of a policy or certificate for a period of five years following the notice of discontinuance to the Commissioner. The Commissioner may waive some or all of the five year period, in his or her discretion.

(f) Except for policies or certificates assumed under an assumption reinsurance agreement, the experience of all policy or certificate forms of the same type for a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation set forth at N.J.S.A. 11:4-23.11(d).

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Prior section 23.9, Requirements for replacement recodified to 23.12. Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on application forms and replacement coverage recodified to 3.15; rule on filing requirements recodified from 23.9: (c) through (f) added.

11:4-23.13 Compensation arrangements

(a) No carrier or other entity shall provide to any producer a first year commission or first year compensation for the sale of Medicare supplement policies or certificates in an amount which exceeds 200 percent of the commission or compensation to be provided by that insurer or other entity for the selling or servicing of that policy or certificate in the second year or period of that policy or certificate.

(b) The commission or other compensation which may be provided in subsequent renewal years shall be, for no fewer than five renewal years, the same as that commission or compensation provided in the second year or period.

(c) No carrier or other entity shall provide compensation or commission to any producer, nor shall any producer receive commission or other compensation greater than the renewal commission or compensation payable by the replacing carrier on renewal policies or certificates when an existing policy or certificate is replaced.

(d) For purposes of this section, "compensation" means a pecuniary or nonpecuniary remuneration of any kind relating to the sale of a policy or certificate, including, but not limited to:

1. Bonuses;
2. Gifts;

3. Prizes;
4. Awards; and
5. Finders fees.

New Rule, R.1990 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Prior section 23.10, Severability recodified to 23.17.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on filing requirements for advertising recodified to 23.16; rule on compensation arrangements recodified from 23.10; compensation arrangement variables restricted further.

11:4-23.14 Required disclosure provisions

(a) General rules concerning disclosure provisions include the following:

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specification of such provision shall be consistent with the type of policy or certificate to be issued. Such provision shall appear on the first page of policies and certificates, and shall include any reservation by the carrier of a right to change premiums and any automatic renewal premium increases based on the policyholder's or certificateholder's age.

2. Except for riders or endorsements by which the carrier effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy or certificate, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits:

i. All riders or endorsements added after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage shall require signed acceptance by the insured;

ii. After the date of the policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium or subscription charges during the policy or certificate term, shall be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by the minimum standards of this State for Medicare supplement coverage, or if required by other law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth clearly.

3. A Medicare supplement policy or certificate shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitation shall appear as a separate paragraph in the policy or certificate and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium or subscription charge or fees refunded if, after examination of the policy or certificate, the insured is not satisfied for any reason.

6. Carriers issuing policies or certificates which provide hospital or medical expense coverage on an expense incurred, indemnity, or service benefit basis to persons eligible for Medicare shall provide to all applicants an informational brochure entitled "Guide to Health Insurance for People with Medicare", hereinafter referred to as "the Guide", in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration. The Guide is intended to improve the buyer's understanding of Medicare and ability to select the most appropriate coverage. Delivery of the Guide shall be made whether or not policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as set forth by this subchapter.

7. To ensure uniformity in content, form and printing, the Guide has been made available through the Publications Department of the National Association of Insurance Commissioners, Kansas City, MO.

8. Except in the case of direct response carriers, delivery of the Guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the Guide shall be obtained by the carrier. Direct response carriers shall deliver the Guide to the applicant upon request but in no instance shall delivery of the Guide occur later than the time of policy or certificate delivery.

9. Except as provided in (c) below, the terms "Medicare Supplement," "Medigap," and words of similar import shall not be used unless the policy or certificate is issued in compliance with N.J.S.A. 11:4-23.8 and all other sections of this subchapter.

(b) Outline of Coverage requirements for Medicare supplement policies and certificates include:

1. Carriers issuing Medicare supplement policies or certificates for delivery in this State shall provide an outline of coverage to all applicants at the time the application is presented to the prospective applicant. Except for direct response policies or certificates, acknowledgment of receipt of such outline shall be obtained by the carrier from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare Supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate actually issued must accompany such policy or certificate when it is delivered

and contain the following statement, in no less than 12 point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3. The outline of coverage provided to applicants pursuant to (b)1 above shall be in the language and format prescribed in Exhibit D of the Appendix to subchapters 16 and 23 of this chapter, incorporated herein by reference, in no less than 12 point type. The outline of coverage shall consist of a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the carrier. All plans A through J shall be shown on the cover page, and the plan(s) offered by the carrier shall be prominently identified. Premium information for the plan(s) offered by the carrier shall be provided on the cover page, or immediately following the coverage page, clearly and prominently, specifying both the premium and the mode. All possible premiums for the applicant on all plans offered to the applicant by the carrier shall be illustrated.

(c) All health and disability income policies, except as specified in this subsection, issued for delivery in this State to persons eligible for Medicare by reason of age shall notify insureds under the policy. Such notice is not required for: Medicare supplement policies; policies of one or more employers or labor organizations, or the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or members or former members, or combination thereof, of the labor organization; or policies issued pursuant to a contract under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.). Such notice shall either be printed or attached to the first page of the outline of coverage delivered to the insureds under the policy, or, if no outline of coverage is delivered, to the first page of the certificate or policy delivered to insureds. Such notice shall be in no less than 12 point type and shall contain the following language:

"THIS IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide, available from the company."

(d) At least 30 days prior to the effective dates of any Medicare benefit changes, notice shall be provided by carriers to New Jersey insureds describing the revisions of the Medicare program and the resulting modifications made by the carrier to an insured's Medicare supplement policy or certificate to eliminate duplication of Medicare benefits.

1. The notices shall be in the format set forth in the Appendix to subchapters 16 and 23 of this chapter, Exhibit C (Notice of Changes in Medicare and Your Medicare Supplement Coverage), which is incorporated herein as part of this rule.

2. No modification shall be made to an existing Medicare supplement policy or certificate when notices are sent except those modifications necessary to eliminate duplication of Medicare benefits.

3. Notices shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate.

4. Notices shall provide information as to when any premium adjustment is to be made due to changes in Medicare.

5. Information on benefit modifications and premium adjustments shall be in outline form and in clear and simple terms to facilitate comprehension.

6. Notices shall not contain or be accompanied by any solicitation.

7. No notice shall contain benefits and premium information for more than one policy or certificate form.

Amended by R.1987 d.95, effective February 2, 1987.

See: 18 N.J.R. 2103(a), 19 N.J.R. 291(a).

(a)6 substantially amended; (a)7 old text deleted and new text substituted.

Amended by R.1988 d.587, effective December 19, 1988 (operative January 1, 1989).

See: 20 N.J.R. 2510(a), 20 N.J.R. 3155(c).

Substantially amended.

Amended by R.1991 d.121, effective March 4, 1991.

See: 22 N.J.R. 771(a), 23 N.J.R. 690(c).

In (a)6 and 7ii: revised internal references; deleted (a)7iv, which was outdated text. In (a)7ii(3)-(4): revised required paper to be used.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section recodified from 23.8.

Deleted "or nonrenewal", "clearly state the duration, where limited, or renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. Such provision shall", "individual" in (a)1. Added (a)2.

Recodified existing (a)2 through 9 as 3 through 10.

Deleted "or hospital or medical service corporation.", "or subscriber", "all" in (a)3.

Designated 3i and ii; deleted "or subscriber".

Added "are required by the minimum standards for Medicare supplement insurance policies, or if" in (a)3ii.

Stylistic changes in (a)4, 5.

Deleted "other than those issued pursuant to direct response solicitation", "policyholder or certificate holder", "person or subscriber", "Medicare Supplement policies or certificates . . ."; added "insured", "or fees"; changed "10" days to "30" days in (a)6.

Deleted "and hospital and medical service corporations", "or subscriber contracts"; added "Delivery of the informational brochure shall be made whether or not policies are advertised, solicited or issued as Medicare supplement policies as set forth by this subchapter." in (a)7.

Changed "format" to "form" in (a)8.

Deleted "or service corporations" in (a)9. Added "and all other sections of this subchapter" in (a)10.

Deleted "or service organizations"; added "or certificates" in (b)1.

Added 5v. in Outline; deleted "N.J.A.C. 11:4-23.8(5)"; added "section 4" in 6 (outline).

Deleted "Any group", "insurance policy or individual or group subscriber contract", "subscriber contract"; added "All", "and disability income policies", "policy" in (c).

Added (d).

Substantial changes in format of the (b)3 outline as follows: Added "And Premium Information" to heading; added "Use this outline to compare benefits and premiums among policies"; added "and indexed copayments or deductibles, as appropriate" in (b)3 outline 4.

Changed "Service" to "Description"; deleted "Benefit" and "Medicare Pays" columns.

Added "I. Minimum Standards . . ."; deleted "Hospitalization" and "Post-Hospital Skilled Nursing Care".

Added "II. Additional Benefits . . .".

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on requirements for marketing recodified to 23.17; rule on required disclosure provisions recodified from 23.11; Outline of Coverage deleted; individualized Medicare supplement plan charts added; new disclosures required.

Amended by R.1996 d.4, effective January 2, 1996.

See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Substantially amended (a)6 and 7.

11:4-23.15 Requirements for application forms and replacement coverage

(a) Application forms shall include the following questions designed to elicit information as to whether a Medicare supplement policy or certificate is intended to replace any Medicare supplement or other health policy or certificate in force, or is intended to be additional to any such policies or certificates. A supplementary application or other form to be signed by the applicant and agent may be used. In the case of a direct response carrier, a copy of the application or supplemental application, signed by the applicant and acknowledged by the carrier, shall be returned to the applicant by the carrier upon delivery of the policy or certificate. The application form or supplementary application form shall contain the questions and statements set forth below.

1. Statements shall be as follows:

i. You do not need more than one Medicare supplement policy.

ii. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

iii. The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

iv. Counseling services may be available in your State to provide advice concerning your purchase of Medicare supplement coverage and concerning Medicaid.

2. Questions, numbered 1, 2, 3 and 4, shall be as follows and shall be prefaced by the statement "To the best of your knowledge":

i. Do you have another Medicare supplement policy or certificate in force, including any health care service

contract or health maintenance organization contract? If so, with which company?

ii. Do you have any other health insurance coverage that provides benefits which this Medicare supplement policy would duplicate?

(1) If so, with which company?

(2) What kind of coverage?

iii. If the answer to question 1 or 2 is yes, do you intend to replace these medical or health coverages with this policy (certificate)?

iv. Are you covered by Medicaid?

(b) Agents shall list any other health policies which they have sold to the applicant that are currently in force, and any such policies sold to the applicant within the previous five years that are no longer in force, clearly indicating which policies are in force and which are not.

(c) Upon determination that a sale will involve replacement of Medicare supplement coverage, a carrier or its agent shall furnish to the applicant, prior to the issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of such notice signed by the applicant and agent, except where coverage is sold without an agent, shall be provided to the applicant, and an additional signed copy shall be retained by the carrier. A direct response carrier shall deliver to the applicant at the time of the issuance of the policy (certificate) the notice regarding replacement of Medicare supplement coverage.

(d) Carriers shall include a waiver of all preexisting condition exclusion clauses, waiting periods, elimination periods or probationary periods in a replacement policy for at least that same period of duration of the conditional clause(s) in the applicant's existing policy which has expired at the time of issuance of the replacement policy, to the extent of the benefits of the existing policy.

(e) The notice required by (c) above shall be provided in substantially the form set forth in Exhibit E of the Appendix to Subchapters 16 and 23 of this chapter, incorporated herein by reference, in no less than 10 point type. Item (1) of the notice set forth in Exhibit E may be omitted or modified if preexisting conditions are covered under the new coverage. If the policy or certificate is guaranteed issue, item (3) of the notice in Exhibit E may be omitted.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section 23.9 "Requirements for replacement" recodified and reworded—"Requirements for application forms and replacement coverage".

Added "or certificate", "or Medicare supplement", "or is intended to be additional to any such policies or certificates", "and agent, except where coverage is not sold through an agent," "the questions shall be substantially as follows:" in (a). Added (a)1 through 4. Added (b), (d). Recodified existing (b) and (c) and (e) as (c), (e) and (f).

Deleted "or service corporation", "signed by the applicant", "certificate"; added "or certificate", "signed by the applicant and the agent, except where coverage is sold without an agent" in recodified (c).

Substantial revision of "Notice to applicant regarding Replacement of Accident and Sickness or Medicare Supplement Coverage" in recodified (e).

Deleted old (d).

Deleted "N.J.A.C. 11:4-23.9(c) and (d)"; added "(e)" and "or modified" in recodified (f).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on appropriateness of recommended purchase and excessive coverage recodified to 23.18; rule on requirements for application forms and replacement coverage recodified from 23.12; "Notice to Applicant . . ." deleted, with reference to Appendix E added; duplication of coverage and value to applicant to be included in application form.

11:4-23.16 Filing requirements for advertising

(a) Every carrier providing Medicare supplement policies or certificates in this State shall file with the Commissioner a copy of all advertisements to which residents of this State will have access, and through which the carrier intends, or by implication purports to the reasonable targeted consumer its intent to make its Medicare supplement product(s) available for purchase or enrollment in this State, whether through written, radio, television or other electronic media, at least 30 days prior to the date on which the advertisement is to be used in this State, or made accessible to residents of this State.

(b) All advertisements shall be in accord with the standards set out in N.J.A.C. 11:2-11 and any other disclosure and advertising rules which may be applicable to carriers.

(c) The Commissioner may disapprove an advertisement at any time if the advertisement is not in compliance with this rule or is in violation of the Trade Practices Act, N.J.S.A. 17B:30-1 et seq. An advertisement which has been disapproved by the Commissioner shall continue to be disapproved until disapproval is withdrawn by the Commissioner.

(d) The Commissioner may institute any and all procedures and penalties available pursuant to N.J.S.A. 17:35C-1 et seq., 17B:26A-1 et seq., and 17B:30-1 et seq., against a carrier which is determined by the Commissioner to be in violation of this rule.

(e) All actions of the Commissioner are subject to review pursuant to the provisions of the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on reporting of multiple policies recodified to 23.19; rule on filing requirements for advertising recodified from 23.13; references to insurer changed to carrier.

Amended by R.1996 d.4, effective January 2, 1996.

See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

11:4-23.17 Standards for marketing

(a) Every carrier, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

2. Establish marketing procedures to assure excessive coverage is not sold or issued to any consumer;

3. Establish procedures for determining whether a replacement policy contains benefits clearly and substantially greater than the benefits provided under the replaced policy and thereby institute guidelines as to when first year commissions or replacement commissions are appropriate pursuant to N.J.A.C. 11:4-23.13;

4. Display prominently by type, stamp or other appropriate means, on the first page of the policy or certificate the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

5. Make every reasonable effort to identify when a prospective applicant or enrollee already has Medicare supplement and/or accident and sickness coverage, the quantity of such policies and extensiveness of such coverage; and

6. Establish procedures which are auditable for purposes of verifying compliance with this section.

(b) Practices which are prohibited in this State, in addition to those set forth in N.J.S.A. 17B:30-1 et seq., include, but are not limited to, the following:

1. Twisting; that is, knowingly making any misleading representations or incomplete or fraudulent comparisons of any policies or carriers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convey any policy or certificate or to purchase any policy with another carrier;

2. High pressure tactics; that is, employing any method of marketing having the effect of or tending to induce the purchase or to recommend the purchase of coverage through force, fright, explicit or implied threat, or undue pressure; and

3. Cold lead advertising; that is, making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance or other similar coverage, and that further contact with the consumer will be made by an insurance agent, other producer or carrier.

New Rule, R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on severability recodified to 23.22; rule on standards for marketing recodified from 23.14; insurer changed to carrier. Amended by R.1996 d.4, effective January 2, 1996. See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

11:4-23.18 Appropriateness of recommended purchase and excessive coverage

(a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of Medicare supplement coverage which will provide an individual with more than one Medicare supplement policy or certificate is prohibited.

New Rule, R.1991 d.345, effective July 1, 1991.
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).
Amended by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on appropriateness of recommended purchase and excessive coverage recodified from 23.15; exception at (b) deleted; prohibition of any sale which provides more than one coverage universal, without exception.

11:4-23.19 Reporting of multiple policies

(a) Every carrier shall report annually, on or before March 1, to the Commissioner, the policy and certificate number and date of issuance of each policy or certificate, grouped by individual insureds for every individual resident of this State for which the carrier has in force more than one Medicare supplement policy or certificate.

(b) Carriers shall submit reports of multiple policies on a form substantially similar to that form set forth in Exhibit G of the Appendix to Subchapters 16 and 23 of this Chapter, incorporated herein by reference. Carriers shall submit separate forms for each insured for which multiple policies or certificates are being reported. No form shall contain information relevant to more than one insured. In any instance in which one form provides insufficient reporting space for an insured's policies or certificates, additional pages should be attached containing the additional information.

New Rule, R.1991 d.345, effective July 1, 1991.
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).
Amended by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on reporting of multiple policies recodified from 23.16, with reporting of multiple sales added; reference to Appendix E added.

11:4-23.20 Addresses for submissions for filing

(a) All forms, rates, loss ratio reporting and advertisements submitted for filing with or by the Commissioner shall be submitted to the Division of Life and Health Actuarial Services, New Jersey Department of Insurance, CN 470, Trenton, New Jersey 08625 directed to specific bureaus as follows:

1. Managed Care Bureau, for submissions from health maintenance organizations, dental plan organizations, and dental service corporations; and
2. Health Bureau, for submissions from insurers and health, hospital and medical service corporations.

(b) Annual reports of multiple policy issues submitted for filing with the Commissioner shall be submitted to the Division of Legislative and Regulatory Affairs, New Jersey Department of Insurance, CN 325, Trenton, New Jersey 08625-0325, to the attention of Medicare Supplement Multiple Policy Report.

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
Substantially amended (a).

11:4-23.21 Penalties

Failure to comply with the terms of this subchapter may result in the assessment of any and all penalties available in accordance with the laws of this State.

11:4-23.22 Severability

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

Amended by R.1991 d.345, effective July 1, 1991.
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).
Section recodified from 23.10.
Changed "rule" to "subchapter" with stylistic changes.
Recodified by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).
Rule on severability recodified from 23.17, without change.

APPENDIX TO SUBCHAPTERS 16 AND 23

EXHIBITS A AND B (RESERVED)

EXHIBIT C

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE

THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

(A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.)

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In (Current Calendar Year) Medicare Pays Per Calendar Year	Effective January 1 (Coming Calendar Year) Medicare Will Pay	In (Current Calendar Year) Your Coverage Pays	Effective January 1 (Coming Calendar Year) Your Coverage Will Pay
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services	All but \$_____ for first 60 days/benefit period	All but \$_____ for first 60 days/benefit period		
Semi-Private Room and Board	All but \$_____ a day for 61st-90th days/benefit period	All but \$_____ a day for 61st-90th days/benefit period		
Misc. Hospital Services and Supplies, such as Drugs, X-Rays, Lab Tests and Operating Room	All but \$_____ a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)	All but \$_____ a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)		

BLOOD	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period
SKILLED NURSING FACILITY CARE	100% of costs for 1st 20 days (after a 3 day prior hospital confinement)/benefit period All but \$_____ a day for 21st-100th days/benefit period Beyond 100 days— Nothing/benefit period	100% of costs of 1st 20 days (after a 3 day prior hospital confinement) benefit period All but \$_____ a day for 21st-100th days/benefit period Beyond 100 days— Nothing/benefit period
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$_____ deductible)	80% of allowable charges (after \$_____ deductible/ calendar year)
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$_____ deductible/calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$_____ deductible/calendar year)
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after \$_____ deductible/calendar year)	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in (after \$_____ deductible/calendar year)

(Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.)

(Describe any coverage provisions due to Medicare modifications.)

(Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.)

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT (Policy) CONTACT:

(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT)

(ADDRESS/PHONE NUMBER)

EXHIBIT D
PART ONE—COVER PAGE(S)

(COMPANY NAME)

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE BENEFIT PLAN(S): (insert letter(s) of plan(s) being offered)

Medicare supplement insurance may be sold in only ten (10) standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your State.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).

Blood: First three (3) pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (\$3,000 Limit)
				Preventive Care					Preventive Care

PREMIUM INFORMATION (Boldface type)

We, (carriers name), may only raise your premium if we raise the premium for all policies like yours in this State. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change.)

PART TWO—DISCLOSURE PAGE(S)

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY (Boldface type)

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY (Boldface type)

If you find that you are not satisfied with your policy, you may return it to (Carrier's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT (Boldface type)

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE (Boldface type)

This policy may not fully cover all of your medical costs.

(for agents:)

Neither (Carrier's name) nor its agents are connected with Medicare.

(for direct response carriers:)

(Carrier's name) is not connected with Medicare.

This outline of coverage does not give all the details of Medicare. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT (Boldface type)

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

plan payments and insured's payments for each plan using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. Include an explanation of any Innovative Benefits on the cover page and in the appropriate chart as specified below.)

PART THREE—PLAN CHARTS

(Include for each plan prominently identified on the cover page, a chart illustrating the services, Medicare payments,

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$628	\$0	\$628 (Part A Deductible)
61st through 90th day	All but \$157 a day	\$157 a day	\$0
91st day and after:			
— While using 60 lifetime reserve days	All but \$314 a day	\$314 a day	\$0
— Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
— Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$78.50 a day	\$0	Up to \$78.50 a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE

MEDICARE APPROVED SERVICES

—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
61st through 90th day	All but \$157 a day	\$157 a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$314 a day	\$314 a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
—Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$78.50 a day	\$0	Up to \$78.50 a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
61st through 90th day	All but \$157 a day	\$157 a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$314 a day	\$314 a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
—Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$78.50 a day	Up to \$78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE

MEDICARE APPROVED SERVICES

— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN D
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
61st through 90th day	All but \$157 a day	\$157 a day	\$0
91st day and after:			
— While using 60 lifetime reserve days	All but \$314 a day	\$314 a day	\$0
— Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
— Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$78.50 a day	Up to \$78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE

Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan

—Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN E
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
61st through 90th day	All but \$157 a day	\$157 a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$314 a day	\$314 a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
—Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$78.50 a day	Up to \$78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE			
Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All Costs

**PLAN F
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
61st through 90th day	All but \$157 a day	\$157 a day	\$0
91st day and after:			
— While using 60 lifetime reserve days	All but \$314 a day	\$314 a day	\$0
— Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
— Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$78.50 a day	Up to \$78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
61st through 90th day	All but \$157 a day	\$157 a day	\$0
91st day and after:			
—While using 60 lifetime reserve days	All but \$314 a day	\$314 a day	\$0
—Once lifetime reserve days are used:			
—Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
—Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$78.50 a day	Up to \$78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE

Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN H
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
61st through 90th day	All but \$157 a day	\$157 a day	\$0
91st day and after:			
— While using 60 lifetime reserve days	All but \$314 a day	\$314 a day	\$0
— Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
— Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$78.50 a day	Up to \$78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%—\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN I

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
61st through 90th day	All but \$157 a day	\$157 a day	\$0
91st day and after:			
— While using 60 lifetime reserve days	All but \$314 a day	\$314 a day	\$0
— Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
— Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$78.50 a day	Up to \$78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE

Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan

—Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%—\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

**PLAN J
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$628	\$628 (Part A Deductible)	\$0
61st through 90th day	All but \$157 a day	\$157 a day	\$0
91st day and after:			
— While using 60 lifetime reserve days	All but \$314 a day	\$314 a day	\$0
— Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
— Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$78.50 a day	Up to \$78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE

Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan

—Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS

SERVICES

FOREIGN TRAVEL—NOT COVERED BY MEDICARE

Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA

	MEDICARE PAYS	PLAN PAYS	YOU PAY
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE

	MEDICARE PAYS	PLAN PAYS	YOU PAY
First \$250 each calendar year	\$0	\$0	\$250
Next \$6,000 each calendar year	\$0	50%—\$3,000 calendar year maximum benefit	50%
Over \$6,000 each calendar year	\$0	\$0	All Costs

SERVICES

PREVENTIVE MEDICARE CARE BENEFIT—NOT COVERED BY MEDICARE

Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare

	MEDICARE PAYS	PLAN PAYS	YOU PAY
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All Costs

(INNOVATIVE BENEFIT)

SERVICES

(Description of benefit)
(Description of conditions, limitations, exclusions, including any applicable deductible and coinsurance requirements)

MEDICARE PAYS	PLAN PAYS	YOU PAY
(Per day or per benefit period, as applicable)	(Per day or per benefit period, as applicable)	(Per day or per benefit period, as applicable)

EXHIBIT E

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE

(Carrier's Name and Address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement coverage and replace it with coverage issued by (Carrier's Name). Your new (policy) (certificate) (coverage) provides thirty (30) days within which you may decide without cost whether you desire to keep the coverage.

You should review this new coverage carefully. Compare it with all accident and sickness and other health coverage

you may have. Terminate your present coverage only if, after due consideration, you find that purchase of this coverage is a wise decision.

STATEMENT TO APPLICANT BY CARRIER, AGENT (BROKER OR OTHER REPRESENTATIVE):

I (We) have reviewed your current medical or health coverage. The replacement involved in this transaction does not duplicate coverage, to the best of my (our) knowledge. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums

Other (please specify):

(1) Health conditions which you presently may have (preexisting conditions) may not be immediately or fully covered under the new (policy) (certificate) (coverage). This could result in denial or delay of a claim for benefits under the new (policy) (certificate) (coverage) whereas a similar claim may be payable under your present coverage.

(2) State law provides that your replacement (policy) (certificate) (coverage) may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods in the new (policy) (certificate) (coverage) for similar benefits to the extent such time had partially or fully expired under the original policy.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to answer truthfully and completely all questions on the application concerning your medical and health history. Failure to include all material medical information on the application may provide a basis for (Carrier's Name) to deny any future claims and to refund your payments as though your (policy) (certificate) (coverage) had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

(4) Do not cancel your present (policy) (contract) (coverage) until you have received your new (policy) (contract) (coverage) and are sure that you want to keep it.

Signature of Agent, Broker or Other Representative

(Direct response carriers may omit this signature line.)

Typed Name and Address of Agent, Broker or Other Representative

(Direct response carriers may omit this signature line.)

The above "Notice to Applicant" was delivered to me on:

Date _____

Applicant's signature _____

Carrier's Name _____

EXHIBIT F

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w) _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Person Completing This Exhibit

Title _____ Telephone Number (____) _____

(a)	(b)
Earned	Incurred
Premium (x)	Claims (y)

Line

1. Current Year's Experience
 - a. Total (all policy years)
 - b. Current Year's issues (z)
 - c. Net (for reporting purpose = 1a - 1b)
2. Past Year's Experience (All Policy Years)
3. Total Experience (Net Current Year + Past Years' Experience)
4. Refunds last year (Excluding Interest)
5. Previous Since Inception (Excluding Interest)
6. Refunds Since Inception (Excluding Interest)
7. Benchmark Ratio Since Inception
(SEE WORKSHEET FOR RATIO 1)
8. Experienced Ratio Since Inception

$$\frac{\text{Total Actual Incurred Claim (line 3, col. b)}}{\text{Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)}} = \text{Ratio 2}$$
9. Life Years Exposed Since Inception _____
 If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.
10. Tolerance Permitted (obtained from credibility table) _____
11. Adjustment to Incurred Claims for Credibility

$$\text{Ratio 3} = \text{Ratio 2} + \text{Tolerance}$$
 If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.
 If Ratio 3 is less than benchmark ratio, then proceed.

12. Adjusted Incurred Claims =

(Total Earned Premiums (line 3, col. a)—Refunds Since Inception (line 6)) × Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col. a)—Refunds Since Inception (line 6)) - (Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1))

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000+	0.0%
5,000-9,000	5.0%
2,500-4,999	7.5%
1,000-2,499	10.0%
500-999	15.0%

If less than 500, no credibility.

- (w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
- (x) Includes model loadings and fees charged.
- (y) Excludes Active Life Reserves
- (z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature _____

Name—Please Type _____

Title _____

Date _____

Reporting Form for the Calculation of Benchmark Ratio Since Inception for Individual Policies for Calendar Year _____

TYPE _____ SMSBP (p) _____
 FOR THE STATE OF _____
 Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____
 Person Completing This Exhibit _____
 Title _____ Telephone Number (____) _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss ratio	(j) (h)x(i)	(o) Policy Year Loss ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception = (l + n) / (k + m)

- (a): Year 1 is the current calendar year minus 1; Year 2 is the current calendar year minus 2; ... etc. ... (Example: If current year is 1991, then Year 1 is 1990; Year 2 is 1989; etc.)
- (b): For calendar year(s) in column (a), the premium earned during each year for policies issued in each specific year.
- (o): These loss ratios are not explicitly used in computing the benchmark loss ratios, but are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown for informational purposes only.
- (p): "SMSBP" means Standardized Medicare Supplement Benefit Plan.

Reporting Form for the Calculation of Benchmark Ratio Since Inception for Group Policies for Calendar Year _____

TYPE _____ SMSBP (p) _____
 FOR THE STATE OF _____
 Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____
 Person Completing This Exhibit _____
 Title _____ Telephone Number (____) _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss ratio	(j) (h)x(i)	(o) Policy Year Loss ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception = (l + n) / (k + m)

- (a): Year 1 is the current calendar year minus 1; Year 2 is the current calendar year minus 2; ... etc. ... (Example: If current year is 1991, then Year 1 is 1990; Year 2 is 1989; etc.)
- (b): For calendar year(s) in column (a), the premium earned during each year for policies issued in each specific year.
- (o): These loss ratios are not explicitly used in computing the benchmark loss ratios, but are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown for informational purposes only.
- (p): "SMSBP" means Standardized Medicare Supplement Benefit Plan.

**EXHIBIT G
 FORM FOR REPORTING MULTIPLE MEDICARE SUPPLEMENT POLICIES**

Company Name _____
 Address: _____

 Phone Number: (____) _____ Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

Signature _____
 Name and Title (please type) _____
 Date _____

Amended by R.1991 d.121, effective March 4, 1992.
 See: 22 N.J.R. 771(a), 23 N.J.R. 690(e).

Amended Appendix text throughout in order to update and clarify changes in Medicare and secondary insurance coverage. Reorganized appendix into Exhibits A through C, with Exhibit C adding new text. Deleted information insert, "Information Concerning Changes to the Medicare Program Effective January 1, 1989," because it is obsolete. Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).
 APPENDIX substantially revised.
 Amended by R.1996 d.4, effective January 2, 1996.
 See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
 Exhibits A and B. repealed.

**SUBCHAPTER 23A. MEDICARE SUPPLEMENT—
 UNDER 50 COVERAGE**

Authority

N.J.S.A. 17:1C-6(e), 17:1-8.1 and P.L.1995, c.229.

Source and Effective Date

R.1996 d.195, effective April 15, 1996.
 See: 27 N.J.R. 3719(a), 28 N.J.R. 1987(a).

11:4-23A.1 Purpose and scope

(a) The purpose of this subchapter is to establish a mechanism to provide Plan C coverage of the standardized Medicare supplement plans to persons under 50 years of age residing in this State who are enrolled in Medicare due to disability, or due to end stage renal disease, until they attain the age of 65.

(b) Except when inconsistent with a provision of this subchapter, the provisions of N.J.A.C. 11:4-23 shall apply.

11:4-23A.2 Definitions

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

“Applicant” means an individual who, at the time of application to the Under 50 Plan, has not attained the age of 50 years. In the event that an applicant for Under 50 Plan coverage is disqualified solely because of age, the date of application to the Under 50 Plan shall be deemed to apply to any application for coverage pursuant to N.J.A.C. 11:4-23B.

“Commissioner” means the Commissioner of the Department of Insurance.

“Contracting carrier” means an insurer selected and appointed to service the Under 50 Plan in accordance with its plan of operation.

“Financially impaired” means an insurer or HMO which, after August 16, 1995, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or an insurer or HMO which is under an order of liquidation, rehabilitation or conservation by a court of competent jurisdiction.

“Health benefits plan” means a hospital and medical expense insurance policy, hospital service corporation contract, medical service corporation contract or health service

corporation contract delivered or issued for delivery in this State or a health maintenance organization subscriber contract delivered or issued for delivery in this State.

“HealthStart Plus” means the program providing coverage to pregnant women and infants up to one year of age who are in families with incomes between 185 percent and 300 percent of the poverty level, established pursuant to the Health Care Cost Reduction Act, P.L. 1991, c.187, section 25 (N.J.S.A. 26:2H-18.47).

“HMO” means a health maintenance organization authorized in accordance with N.J.S.A. 26:2J-1 et seq.

“Insurer” means an insurance company or hospital, medical or health service corporation authorized to issue health benefits plans in this State.

“Medicaid” means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.) and amendments thereto.

“Net earned premium” means the premium earned in New Jersey on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plans. “Net earned premium” shall include the aggregate premiums earned in the insurer’s insured group and individual business and HMO business, including premiums from contracts covering Medicaid and HealthStart Plus recipients and premiums from Medicare cost and risk contracts. “Net earned premium” shall not include premiums from any stop loss or excess coverage to the extent that such coverage:

1. Is issued to self-funded arrangements to reimburse only the self-funded arrangements for expenses exceeding per person or aggregate limits, and for which employees or other individuals are not third party beneficiaries under the policy; and
2. The per person limit is no less than \$25,000 per year, and additionally, or in the alternative, the aggregate limit is no less than 110 percent of expected claims.

“Net loss of the contracting carrier” means net earned premiums and any investment income thereon less the amount in claims and reasonable administrative expenses of the contracting carrier paid in the preceding calendar year.

“Net loss of the Under 50 Plan” means the net loss of the contracting carrier plus any administrative expenses of the governing board and any other associated administrative expenses.

“Reasonable administrative expenses of the contracting carrier” means actual expenses or the expense allowance.

but in no event shall the administrative expenses exceed 25 percent of premium.

11:4-23A.3 Creation of Medicare Supplement—Under 50 Coverage Plan

(a) There is created in the State of New Jersey a plan to provide Medicare Supplement Plan C coverage of the standardized Medicare supplement plans to New Jersey residents under 50 years of age, and until they attain the age of 65, who are enrolled in Medicare due to disability or due to end stage renal disease to be known as the Medicare Supplement—Under 50 Plan (“Under 50 Plan”).

(b) The Under 50 Plan shall be administered by a governing board appointed pursuant to this subchapter and a plan of operation adopted by the governing board and approved by the Commissioner.

(c) Any administrative office of the governing board of the Under 50 Plan shall be located within the State of New Jersey and all meetings of the governing board shall take place in New Jersey. The contracting carrier shall at all times maintain an office and records relating to the Under 50 Plan in the State of New Jersey.

(d) Coverage by the Under 50 Plan shall be provided through a contracting carrier appointed pursuant to this subchapter and the approved plan of operation.

(e) Annually, no later than 120 days after December 31st, the governing board of the Under 50 Plan shall submit to the Commissioner a financial report in a form approved by the Commissioner and an operational report of its activities during the preceding calendar year.

11:4-23A.4 Governing board

(a) The Under 50 Plan shall be administered by a governing board composed of eight directors, one of whom shall be the Commissioner or the Commissioner’s designee, one of whom shall be the contracting carrier upon its selection and appointment by the governing board, and six of whom shall be appointed by the Commissioner as follows:

1. Two directors shall be insurers writing Medicare Supplement insurance coverage in this State;
2. One director shall be an HMO nominated by the New Jersey Association of Health Maintenance Organizations;
3. One director shall be an insurer nominated by the Health Insurance Association of America; and
4. Two directors shall be members of the public who are knowledgeable about Medicare Supplement coverages, but who are not employed by or otherwise affiliated with insurers, health maintenance organizations, insurance producers, or other entities of the insurance industry.

(b) No insurer or HMO, its affiliates or subsidiaries shall serve in more than one director position on the governing board at the same time.

(c) The Commissioner, or the Commissioner’s designated representative, shall sit ex-officio, and shall be a non-voting member of the governing board.

(d) The initial directors appointed to the governing board pursuant to this subchapter shall serve for staggered terms of one or two years, as determined by the Commissioner, or until successors are appointed. Thereafter, all directors of the governing board shall serve for two years or until a successor is appointed.

(e) Each director, other than the two directors who are members of the public, shall designate a primary and an alternate representative to serve on the governing board.

(f) Directors shall serve without compensation but directors who are members of the public may be reimbursed for reasonable expenses as set forth in the plan of operation.

(g) All meetings of the governing board shall be conducted in accordance with this subchapter and the approved plan of operation.

(h) The governing board shall have the power and duty to:

1. Develop and submit to the Commissioner for approval a plan of operation;
2. Establish minimum requirements and performance standards for the contracting carrier, which shall include evidence of prior experience in providing and servicing standardized Medicare supplement insurance policies or contracts in this State;
3. Establish procedures to select an auditor to review the operations of the contracting carrier relating to the Under 50 Plan;
4. Review the auditor’s report and implement any recommendations determined to be appropriate;
5. Retain appropriate actuarial, accountant, or other employees, professionals and contractors as necessary to provide technical assistance in the operation of the Under 50 Plan; and
6. Perform such other functions as may be necessary and proper in accordance with this subchapter and the approved plan of operation.

11:4-23A.5 Plan of operation

(a) The plan of operation shall provide for the fair, reasonable and equitable administration of the Under 50 Plan and shall include:

1. The internal organization and proceedings of the governing board;

(b) Nothing in (a) above shall be construed to prohibit the exclusion of benefits under a policy or contract during the first three months, based on a preexisting condition for which the insured received treatment or was otherwise diagnosed during the six months before the policy or contract became effective, except that this limitation shall not apply to an individual who has, under a prior health benefits policy or contract, with no intervening lapse in coverage, been treated or diagnosed for a condition under that policy or contract or satisfied a three month preexisting condition limitation.

11:4-23B.4 Rates

Rates for Medicare supplement insurance policies or contracts issued pursuant to section 2 of P.L. 1995, c.229 shall be no greater than the lowest rate charged by the insurer for the same type of policies or contracts issued to persons 65 years of age or older and shall be calculated and filed in accordance with N.J.A.C. 11:4-23.11 and 23.12.

SUBCHAPTER 24. SMOKER AND NONSMOKER MORTALITY TABLES

11:4-24.1 Purpose

The purpose of this subchapter is to authorize the use of mortality tables adopted after September 11, 1981 by the National Association of Insurance Commissioners in determining minimum nonforfeiture standards and minimum valuation standards.

11:4-24.2 Definitions

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

“1980 CSO Table” means that mortality table, consisting of separate rates of mortality for male and female lives, prescribed by N.J.S.A. 17B:19-8a(i) and N.J.S.A. 17B:25-19h(viii) and referred to therein as the Commissioners 1980 Standard Ordinary Mortality Table, with or without Ten Year Mortality Factors.

“1980 CET Table” means that mortality table, consisting of separate rates of mortality for male and female lives, prescribed by N.J.S.A. 17B:25-19h(viii) and referred to therein as the Commissioners 1980 Extended Term Insurance Table.

“1958 CSO Table” means that mortality table prescribed by N.J.S.A. 17B:9-8a(i) and N.J.S.A. 17B:25-19g and referred to therein as the Commissioners 1958 Standard Ordinary Mortality Table.

“1958 CET Table” means that mortality table prescribed by N.J.S.A. 17B:25-19g and referred to therein as the Commissioners 1958 Extended Term Insurance Table.

“Composite mortality tables” means the 1980 CSO, 1980 CET, 1958 CSO and 1958 CET mortality tables defined above, as they were originally published with rates of mortality that do not distinguish between smokers and non-smokers.

“Juvenile” means a person or persons under 15 years of age.

“Smoker and nonsmoker mortality tables” means the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the 1980 CSO, 1980 CET, 1958 CSO and 1958 CET tables defined above and approved by the National Association of Insurance Commissioners in December 1983.

Amended by R.1996 d.81, effective February 20, 1996.
See: 27 N.J.R. 3723(a), 28 N.J.R. 1214(a).
Added “Juvenile”.

11:4-24.3 Smoker and nonsmoker mortality tables

(a) In determining minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits, and minimum reserve liabilities for any policy of insurance delivered or issued for delivery in this State after the operative date of N.J.S.A. 17B:25-19h(xi) for that policy form and before January 1, 1989, at the option of the insurer and subject to the conditions in (e) below, the following tables may be substituted:

1. The 1958 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table; and
2. The 1958 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Table.

(b) For any category of insurance issued on female lives using 1958 CSO or 1958 CET Smoker and Nonsmoker Mortality Tables in determining minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits, and minimum reserve liabilities, such minimum values may be calculated according to an age not more than six years younger than the actual age of the insured.

(c) Once an election has been made to use a 1980 CSO Mortality Table for a plan of insurance, the substitution in (a) above shall not be available for any subsequent new plan of insurance.

(d) In determining minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits, and minimum reserve liabilities for any policy of insurance delivered or issued for delivery in this State after the operative date of N.J.S.A. 17B:25-19h(xi) for that policy, at the option of the insurer and subject to the conditions in (e) below, the following tables may be substituted.

1. The 1980 CSO Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CSO Table; and

2. The 1980 CET Smoker and Nonsmoker Mortality Tables may be substituted for the 1980 CET Tables.

(e) For each policy form with separate rates for smoker and nonsmoker, an insurer may:

1. Use composite mortality tables to determine minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits and minimum reserve liabilities;

2. Use smoker and nonsmoker mortality tables to determine the valuation net premiums and minimum reserves, if any, required by N.J.S.A. 17B:19-8e and use composite minimum amounts and minimum periods of nonforfeiture benefits and basic minimum reserve liabilities; or

3. Use smoker and nonsmoker mortality tables to determine minimum cash surrender values, minimum amounts and minimum periods of nonforfeiture benefits and minimum reserve liabilities.

11:4-24.4 Juvenile insureds

(a) Because the smoker and nonsmoker mortality tables do not extend below age 15, the Department shall permit the following uses of the composite and smoker and nonsmoker mortality tables for juvenile insureds, as hereafter provided:

1. Insurers may use the composite mortality table for juvenile issues and continue to use such table for all future attained ages; or

2. Insurers may use the composite mortality table for juvenile issues and change to use of a smoker and nonsmoker mortality table when the insured's attained age is a specified age between 15 and 23. The insurer shall classify the insured as a nonsmoker upon the insured's reaching such attained age unless the insured is notified in writing of his or her option to elect smoker or nonsmoker status at least 30 days prior to the effective date of the change in mortality tables and the insured fails to elect smoker status.

3. Insurers may use a reasonable extrapolation of the smoker and nonsmoker mortality tables for ages 15 and below. The submission shall include an actuarial memorandum which describes the basis for the extrapolation.

(b) Insurers may classify a juvenile as a smoker only if, at the time of the application, the juvenile responds to a smoking question in the affirmative.

1. Insurers may contest the response to the question concerning smoking status only if the contract specifically reserves such right, there is an entire contract provision in the policy which states that the application for the change in smoking status is attached to and made a part of the policy and the submission describes the settlement payable upon a successful contest. A contest shall be limited to the amount of coverage which is purchased by the difference between the smoker and nonsmoker rates.

2. If the insurer intends to waive the right to contest, the submission should include a statement to that effect from a company officer.

(c) The policy must accurately describe all mortality tables used as composite, smoker and nonsmoker, or extrapolation for all ages.

(d) In fixed premium contracts, a change in smoker/nonsmoker classification pursuant to (a)2 above shall affect premium rates only and not the guaranteed nonforfeiture benefits. A fixed premium contract which provides for changes in smoker/nonsmoker classification pursuant to (a)2 above shall specify the guaranteed maximum smoker and nonsmoker premium and the insurer shall charge the guaranteed maximum nonsmoker premium at the attained age unless the insurer notifies the insured of his or her option to elect smoker or nonsmoker status at least 30 days prior to the effective date of the change in classification and the insured fails to elect smoker status.

New Rule, R.1996 d.81, effective February 20, 1996.
See: 27 N.J.R. 3723(a), 28 N.J.R. 1214(a).

11:4-24.5 Separability

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

Recodified from 11:4-24.4 by R.1996 d.81, effective February 20, 1996.
See: 27 N.J.R.3723(a), 28 N.J.R.1214(a).

SUBCHAPTER 25. (RESERVED)

SUBCHAPTER 26. ANNUITY MORTALITY TABLES

11:4-26.1 Purpose

The purpose of the new subchapter is to recognize new mortality tables, the 1983 Table "a" and the 1983 GAM Table, for use in determining the minimum standard of valuation for annuity and pure endowment contracts.

11:4-26.2 Definitions

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

"1983 Table 'a'" means that mortality table adopted as a recognized mortality table for annuities in June, 1982 by the National Association of Insurance Commissioners.