

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.)

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT  
INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

Check the coverage in all health insurance policies you already have.

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(Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.)

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT  
INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

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- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling service.

(Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.)

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THIS IS NOT MEDICARE SUPPLEMENT  
INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

#### Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.1999 d.161, effective May 17, 1999.

See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

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

### 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.

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

Amended by R.1997 d.61, effective February 3, 1997.

See: 28 N.J.R. 4705(b), 29 N.J.R. 446(a).

At the end of (a), deleted " , until they reach the age of 65".

### 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 or 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 \$20,000 per year, and additionally, or in the alternative, the aggregate limit is no less than 125 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.

“Resident” means a person whose primary residence for the majority of a year is in the State of New Jersey.

Amended by R.1997 d.61, effective February 3, 1997.

See: 28 N.J.R. 4705(b), 29 N.J.R. 446(a).

Added “Resident” and amended “Net earned 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 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.

Amended by R.1997 d.61, effective February 3, 1997.

See: 28 N.J.R. 4705(b), 29 N.J.R. 446(a).

In (a), deleted “, until they reach the age of 65,” following “residents under 50 years of age”.

#### **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;

2. Procedures to select, appoint, terminate and compensate a contracting carrier to service the Under 50 Plan coverage;

3. Procedures in accordance with section 4 of P.L. 1995, c.229 for the equitable sharing of any losses incurred by the Under 50 Plan;

4. Procedures for handling complaints and appeals to the governing board;

5. Procedures for individuals to apply for coverage;

6. Procedures for cancellation or nonrenewal of coverage, including refunds of unearned premium;

7. Procedures for the collection, investment and disbursement of funds; and

8. Such other provisions as are deemed necessary by the governing board for the proper operation of the Under 50 Plan.

(b) No later than 30 days after appointment, the governing board shall hold its initial organizational meeting. The governing board shall within 60 days of its initial organizational meeting submit to the Commissioner for the Commissioner's approval, a proposed plan of operation. If approved, the Commissioner shall certify approval to the governing board.

1. If the Commissioner disapproves all or part of the plan of operation or an amendment, the Commissioner shall return same to the governing board with a statement that sets forth the reasons for disapproval and may include other recommendations the Commissioner may wish to make.

2. If the governing board does not submit a plan of operation within the time provided by these rules, or a new plan of operation which is acceptable to the Commissioner within 30 days after the disapproval of a proposed plan, the Commissioner may promulgate a temporary plan of operation and certify same to the governing board, which shall remain in effect until such time as the Commissioner approves and certifies to the governing board a permanent plan of operation proposed by the governing board.

3. The governing board shall review the plan of operation at least annually and may propose amendments to the plan of operation for review and approval by the Commissioner. The Commissioner may review the plan of operation at any time and may recommend amendments to the governing board.

#### 11:4-23A.6 Open enrollment

(a) The Under 50 Plan shall not deny or condition the issuance or renewal, nor discriminate in the pricing of coverage because of the health status, claims experience, receipt of health care or medical condition of an applicant if the application for coverage is submitted during the six-

month period beginning with the first month in which an individual is enrolled for benefits under Medicare Part B or if the application is submitted within six months of the approval of a plan of operation pursuant to this subchapter, whichever is later.

(b) Nothing in (a) above shall be construed to prohibit the exclusion of benefits 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.

#### 11:4-23A.7 Rates

The rates for Under 50 Plan coverage shall be no greater than the lowest rate charged by the contracting carrier for Medicare Supplement Plan C policies or contracts issued by the contracting carrier to persons 65 years of age or older.

#### 11:4-23A.8 Reports

(a) By March 1, 1996 and following the close of each calendar year thereafter, on a date set by the Commissioner:

1. Every insurer and HMO in this State shall file with the Commissioner its net earned premium in the preceding calendar year;

2. The contracting carrier shall file with the Commissioner its net earned premiums and investment income on Under 50 Plan contracts and the claims paid and administrative expenses attributable to those contracts in the preceding calendar year; and

3. The contracting carrier shall file with the Commissioner any net loss for Under 50 Plan contracts in the preceding calendar year along with any supporting information requested by the Commissioner.

#### 11:4-23A.9 Equitable sharing of losses and audit

(a) Net losses of the Under 50 Plan shall be apportioned among insurers and HMOs as set forth in the plan of operation of the Under 50 Plan.

(b) Assessments for net losses of the Under 50 Plan may be determined or apportioned, and may include calculations based upon the information provided pursuant to N.J.A.C. 11:4-23A.8, but the contracting carrier shall not be reimbursed for its total reported net losses until the conclusion of an audit of the losses reported by the contracting carrier and its related operations, conducted in accordance with the Under 50 Plan of operation. The contracting carrier may be paid for a portion of its reported net losses prior to the completion of the audit, as provided in the Under 50 Plan plan of operation. The cost of such audit shall be paid as an administrative expense of the Under 50 Plan.

#### 11:4-23A.10 Assessments

(a) Every insurer and HMO providing health benefits plans or health maintenance organization subscriber con-

tracts in this State shall be liable for an assessment to pay its equitable share of any net loss incurred by the Under 50 Plan in the previous calendar year, unless the insurer or HMO has received an exemption or deferment from the Commissioner.

(b) The assessment of each insurer and HMO described in (a) above shall be in the proportion that its net earned premium bears to the net earned premium of all insurers and HMOs, except that no insurer or HMO shall be liable for an assessment amount greater than 35 percent of the total net loss incurred by the Under 50 Plan in any calendar year.

(c) Assessment amounts for insurers or HMOs granted a deferment or exemption, or that portion of assessment that exceeds the 35 percent limit noted in (b) above, shall be reapportioned to other insurers and HMOs based on their respective adjusted market share.

(d) Assessments shall be due and payable upon receipt by the insurer or HMO of the invoice for the assessment. Any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice shall be subject to interest of 1.5 percent of the assessment amount not timely paid per month, accruing from the date of the invoice of the assessment.

#### 11:4-23A.11 Appeal to the Commissioner

(a) Any person may petition for appeal to the Commissioner from an adverse decision of the governing board by filing a request in writing within 20 days of the date of receipt of the written decision of the governing board.

1. The written request to appeal shall set forth the facts upon which it is based and include a copy of the written decision of the governing board.

2. The Commissioner shall notify the petitioner and the governing board within 30 days whether the request to appeal shall be granted.

3. Notice from the Commissioner that an appeal has been granted pursuant to this section shall also provide a statement about whether the action of the governing board has been stayed pending the disposition of the appeal.

(b) An appeal to the Commissioner granted pursuant to this section shall be conducted on the record before the governing board.

#### 11:4-23A.12 Assessment relief requests

(a) An insurer or HMO seeking relief from any assessment imposed pursuant to section 4 of P.L. 1995, c.229 shall submit to the Department a request for such relief no later than 15 days prior to the due date of payment of the assessment.

(b) Each request shall be in loose leaf form inserted into two-ring or three-ring binders tabbed or otherwise indexed to correspond to the exhibits set forth in (f) below. The loose leaf sheets used in the request shall be eight and one-half inches wide and 11 inches long and punched for two-ring or three-ring binders, as appropriate.

(c) All insurers and HMOs requesting relief pursuant to this rule shall submit five copies of each request in the format set forth in (b) above.

(d) If a request fails to materially comply with the filing format and information requirements set forth in this section, the Department shall notify the insurer or HMO that its request for relief is deficient and is denied on such grounds. The notice shall also set forth any information or other action required to cure the deficiency. The insurer or HMO shall submit the additional information or otherwise submit a filing in accordance with the format requirements specified in this rule within 15 days of receipt of the Department's notice of deficiency. Failure to submit within 15 days the information necessary in the proper format to cure the deficiency shall result in the request being denied.

(e) All requests for relief or other information required pursuant to this section shall be filed with the Department at the following address:

Under 50 Plan  
Request for Relief  
New Jersey Department of Insurance  
Division of Financial Solvency  
20 West State Street  
CN 325  
Trenton, New Jersey 08625

(f) When requesting relief from assessments imposed pursuant to section 4 of P.L. 1995, c.229, an insurer or HMO shall provide with its request the following information in a clear, concise and complete manner:

1. A cover letter stating:
  - i. The name of the applicant;
  - ii. The form of relief and, if a deferral of less than the full amount, the specific amount/percentage of relief which the applicant is requesting;
  - iii. A statement of facts relied upon as the basis under which relief is sought, including the specific reasons for which the Commissioner may find that the applicant is or would be placed in a financially impaired position; and
  - iv. The name, title, telephone number and telefax number of a contact person familiar with the filing to whom the Department may direct additional questions;

2. A detailed explanation, with supporting documentation, of the projected effect that fulfillment of the obligation would have on the immediate and long term financial condition of the applicant unless relief is granted as requested;

3. The most recent financial examination report, whether conducted by the applicant's state of domicile or another state;

4. A statement addressing whether the applicant is planning to modify its method of doing business in any way including, but not limited to, new acquisitions or new restructuring;

5. If the applicant is a member of a holding company system, the following shall be provided:

i. A list of all members of the holding company system;

ii. A list of all intercompany transactions for the period beginning January 1 in the year of the filing to the date of the quarterly statement immediately preceding the date of filing, in the format set forth in the statutory annual statement filed by the applicant; and

iii. A copy of the applicant's organizational chart;

6. An actuarial opinion attesting to the adequacy of reserves specifically for all accident and health lines of business, and for all lines of business which the applicant transacts, in the format of and satisfying all requirements for the actuarial opinion and memorandum required to be submitted as a part of the annual statement filed by the applicant;

i. If the applicant is an HMO, the applicant shall obtain and file an actuarial opinion which complies with the requirements set forth in (f)6 above;

7. A report signed by the attesting actuary referred to in (f)6 above, which includes, in summary form if necessary, all data utilized, a complete explanation of methods and assumptions and sufficient additional narrative to account for any features of the data or circumstances necessary for proper interpretation;

8. A copy of the annual statement of the applicant, including all accompanying exhibits, filed with this State immediately preceding the date of the relief filing;

9. Copies of all quarterly statements for the period beginning January 1 in the year of the filing to the quarterly statement immediately preceding the date of the filing;

10. A description of any relief from obligations imposed by this State or any other state granted or in effect within the preceding 12 months, and the basis upon which such relief was granted; and

11. Any other information the Commissioner may deem relevant to the consideration of the request.

(g) All data or information contained in the request for relief filed pursuant to this section shall be confidential and not be subject to public disclosure or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A-1 et seq., except for the following, but only upon written, specified request and following 10 days' written notice by the Department to the applicant:

1. N.J.A.C. 11:4-23A.12(f)1i and ii—cover letter with name of applicant and describing relief sought;

2. N.J.A.C. 11:4-23A.12(f)1iv—name, title, telephone number and telefax number of person familiar with the filing;

3. N.J.A.C. 11:4-23A.12(f)3—most recent financial examination information report;

4. N.J.A.C. 11:4-23A.12(f)5i and ii—list of members of holding company system and intercompany transactions for period preceding date of filing;

5. N.J.A.C. 11:4-23A.12(f)8—annual statement filed immediately preceding date of filing; and

6. N.J.A.C. 11:4-23A.12(f)11—additional information required by the Commissioner to evaluate a particular filing.

(h) When the Commissioner determines pursuant to section 4 of P.L. 1995, c.229, that the applicant is or would be placed in a financially impaired condition through imposition of an assessment obligation, the Commissioner shall notify the applicant that its duty to fulfill the applicable obligation shall be waived, or deferred in whole or in part, as appropriate.

(i) The Commissioner shall find that an applicant is or would be financially impaired if:

1. The applicant has been placed in rehabilitation or conservation pursuant to N.J.S.A. 17B:32-31 et seq., or such similar law of the applicant's state of domicile;

2. The Commissioner finds that the applicant is in hazardous financial condition, as determined pursuant to N.J.A.C. 11:2-27; or

3. The Commissioner finds that fulfillment of the obligation from which relief is sought would place the applicant in a hazardous financial condition, as determined pursuant to N.J.A.C. 11:2-27.

(j) If the Commissioner denies an applicant's request for relief made pursuant to this section, or if the applicant objects to the terms of the relief granted, the applicant may request a hearing on the Commissioner's determination within seven days from the date of receipt of such decision as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, and daytime telephone number of a contact person familiar with the matter;

ii. A copy of the Commissioner's determination;

iii. A statement requesting a hearing; and

iv. A concise statement describing the basis for which the applicant believes that the Commissioner's findings of fact are erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide for an informal conference between the applicant and such personnel of the Department as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

3. The Commissioner shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

i. If the Commissioner finds that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

ii. In a matter which has been determined to be a contested case, if the Commissioner finds that there are no good-faith disputed issues of material facts and the matter may be decided on the documents filed, the Commissioner may notify the applicant in writing as to the final disposition of the matter.

## SUBCHAPTER 23B. MEDICARE SUPPLEMENT— AGE 50 THROUGH 64 COVERAGE

### 11:4-23B.1 Purpose and scope

(a) Every insurer issuing or renewing standardized Medicare supplement insurance policies or contracts in this State shall offer, at a minimum, Medicare Supplement Plan C policies or contracts to New Jersey residents 50 years of age or older who are enrolled in Medicare due to disability or due to end stage renal disease, except that:

1. An insurer that does not currently issue or renew individual standardized Medicare supplement insurance policies or contracts and does issue or renew standardized Medicare supplement insurance policies or contracts for groups whose membership in the group is not based on health status, claims experience, receipt of health care or medical condition, shall not be required to provide coverage, other than to members of the group.

2. No group to which the provisions of (a)1 apply shall institute an age requirement for participation in the group on or after June 1, 1995.

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

### 11:4-23B.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 an insurer, has attained the age of 50 years but not attained the age of 65 years. In the event that an applicant for coverage pursuant to this subchapter is disqualified solely because of age, the date of the original application to the insurer shall be deemed to apply to any application for Under 50 Plan coverage pursuant to N.J.A.C. 11:4-23A where the individual under 50 years of age, or to any application pursuant to N.J.A.C. 11:4-23 where the individual is 65 years of age or older.

“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.

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

### 11:4-23B.3 Open enrollment

(a) No insurer shall deny or condition the issuance or renewal, or discriminate in the pricing of Medicare supplement policies or contracts available pursuant to section 2 of P.L. 1995, c.229 because of the health status, claims experience, receipt of health care or medical condition of an applicant if the application for a policy or contract is submitted during the six-month period beginning with the first month in which an individual is enrolled for benefits under Medicare Part B or if the application is submitted within six months of August 16, 1995.

(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.