

ii. Any underwriting requirements that must be satisfied in order to exercise the option (income limits, health status, other insurance) must be specified in the option. The option may not state that no evidence of insurability is required, if such underwriting criteria are imposed.

iii. The time limit on certain defenses for the additional insurance shall run from the date of the original policy for the duration specified in the original policy, except that such time limit may run from the effective date of the additional insurance for any representations material to the issue of new insurance.

iv. Prior to each option date, the insurer shall notify the insured of the availability of the additional insurance. Such notice shall be given in sufficient time to exercise the option.

v. Guaranteed insurability options may only provide for additional coverage, without evidence of insurability, of a kind directly comparable to the kind of coverage provided by the basic policy to which the option is attached.

21. Policies which reduce benefits at a specified age shall only be issued at ages which provide full coverage for at least five years. This rule shall not apply to hospital-medical expense benefits or hospital indemnity benefits which are reduced at the Medicare eligible age nor to disability income benefits where the basis for the reduction is retirement at 65 or a later age.

22. Termination of the policy shall be without prejudice to any claim for continuous loss which commenced while the policy was in force; however, the payment of benefits after the termination date may be predicated upon the continuous disability of the insured, limited to the duration of the benefit period or payment of the maximum benefits.

(d) "Basic hospital expense coverage" is a health insurance policy which provides coverage for a period of not less than 31 days for one period of hospital confinement of each covered person for expenses incurred for necessary treatment and services rendered as a result of injury or sickness for at least the following:

1. Daily hospital room and board, including general nursing care and special diets, in an amount not less than the lesser of:

- i. 80 percent of the charges for semi-private accommodations; or
- ii. The Statewide average semi-private hospital room and board charge at the time the policy is issued, as determined by the New Jersey Department of Health.

2. Miscellaneous hospital services, for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospi-

tal and provided for use only during any one period of confinement in an amount not less than 80 percent of the charges incurred up to at least \$1800 or 10 times the daily hospital room and board benefits; and

3. Hospital outpatient services, consisting of:

- i. Hospital services on the day surgery is performed;
- ii. Hospital services rendered within 72 hours after accidental injury, in an amount not less than \$50; and
- iii. X-ray and laboratory tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital, in an amount not less than \$100.

4. Benefits provided under (d)1 and 2 above may be provided subject to a combined deductible amount not in excess of \$100.00.

(e) "Basic medical-surgical expense coverage" is a health insurance policy which provides coverage for each covered person for expenses incurred for the necessary services rendered by a physician for treatment of injury or sickness for at least the following:

1. Surgical services in an amount not less than:

- i. 80 percent of the reasonable charges; or
- ii. Those based on a relative value fee schedule with a maximum of at least \$500 for the most severe procedure. Acceptable relative value fee schedules include, but are not limited to, the New York certified surgical fee schedule or the 1964 California Relative Value Schedule.

2. Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical services rendered by a physician other than the physician (or his assistant) performing the surgical services in an amount not less than:

- i. 80 percent of the reasonable charges; or
- ii. 15 percent of the surgical service benefit.

3. In-hospital services, consisting of physicians' services rendered to a person who is hospital confined, for treatment of injury or sickness other than that for which surgical care is required, in an amount not less than:

- i. 80 percent of the reasonable charges; or
- ii. One percent of the maximum surgical fee for each day for not less than 21 days during one period of confinement.

(f) Major medical expense coverage includes:

1. "Major medical expense coverage" is a health insurance policy which provides hospital, medical and surgical expense coverage for each covered person to a maximum of not less than \$10,000; copayment by the covered person not to exceed 25 percent of covered charges; a

deductible stated on a per person, per family, per illness, per benefit period or per year basis or combination of such bases, not to exceed five percent of the maximum limit under the policy. The policy shall provide at least the following benefits for each covered person after application of the copayment percentage.

i. Daily hospital room and board expenses as defined in (b)1 above for a period of not less than 31 days during one period of hospital confinement;

ii. Miscellaneous hospital services for a maximum of not less than \$1800 or 15 times the daily room and board rate if specified in dollar amounts during one period of hospital confinement;

iii. Surgical services to a maximum of not less than \$600.00 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

iv. Anesthesia services for a maximum of not less than 15 percent of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

v. In-hospital medical services as defined in (e)3 above;

vi. Out-of-hospital care consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician;

vii. Prosthetic appliances, meaning artificial limbs or other prosthetic appliances (except replacements thereof);

viii. Casts, splints, trusses, or braces; and

ix. Not fewer than three of the following additional benefits for a maximum of such covered charges of not less than \$1000:

(1) In-hospital private duty graduate registered nurse services;

(2) Convalescent nursing home care;

(3) Diagnosis and treatment by a radiologist or physiotherapist;

(4) Rental or special medical equipment, as defined by the insurer in the policy;

(5) Treatment for functional nervous disorders, and mental and emotional disorders; and

(6) Out-of-hospital prescription drugs and medications.

2. Alternatively, "major medical expense coverage" is a health insurance policy which provides hospital, medical and surgical expense coverage for each covered person to a maximum of not less than \$25,000; copayment by the covered person not to exceed 25 percent of covered charges; a variable deductible on a per person, per family, per illness, per benefit period or per year basis or a combination of such bases, for at least the amounts described in (f)1i through ix above and which meets the following conditions:

i. The deductible is defined as the greater of a minimum deductible of not less than \$1500 or the amount of other medical expense coverage.

ii. The amount of covered expenses required to be incurred during a claim qualification period cannot exceed the minimum deductible.

iii. The policy includes a provision allowing the insured to change the amount of the Minimum Deductible under stated conditions as to evidence of insurability, notice and effective date.

iv. An annual notice is sent to New Jersey insureds advising them of their right to change the Minimum Deductible if their circumstances have changed.

v. If the minimum deductible exceeds \$10,000, the benefit period does not begin until covered expenses exceed the deductible.

vi. If the minimum deductible exceeds \$10,000, the claim qualification period is not less than 18 months.

(g) Disability income protection coverage shall be subject to the following standards:

1. "Disability income protection coverage" is a health insurance policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which:

i. "Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50 percent of amounts payable immediately prior to 62;

ii. Contains an elimination period no greater than:

(1) 90 days in the case of coverage providing a benefit of one year or less;

(2) 180 days in the case of coverage providing a benefit of more than one year but not greater than two years; or

(3) 365 days in all other cases during the continuance of disability resulting from sickness or injury;

iii. If a policy contains an elimination period in excess of six months, provides a premium waiver disability benefit which becomes operative not later than six months after commencement of total disability regardless of whether or not income indemnity is then payable, or provides for full reinstatement without evidence of insurability during a continuous period of total disability if the policy has lapsed after the sixth month of the elimination period;

iv. Has a maximum period of time for which benefits are payable during disability of at least six months except in the case of a policy covering disability arising out of normal pregnancy or childbirth in which case the period for such disability may be one month;

v. If the policy terminates benefits at a specified age, provides a minimum benefit period of at least one year or the length of the benefit period if less than one year;

vi. Where a policy provides that periodic payments are reduced if the insured is not gainfully employed away from the home, provides a benefit which is at least 50 percent of the full periodic payment and for return of the pro rata unearned premium for the period the insured is not so employed.

Paragraph (g)1 above does not apply to business buyout coverage.

2. Elimination periods which do not comply with (g)1ii above may be used on a supplemental basis as an additional benefit to an individual disability income policy which otherwise complies with (g)1ii, if the insurer submits the following to the Department:

i. A specimen copy of that part of the policy which illustrates how the supplemental premium rates will be shown; and

ii. A certification by an officer of the insurer that:

(1) Every individual disability income policy issued by the company will contain an elimination period/benefit period combination which complies with (g)1ii above;

(2) Supplemental individual disability income benefits which are not in compliance with (g)1ii above will only be used to provide additional coverage on an individual disability income policy issued by the insurer which has an elimination period/benefit period combination which is in compliance with (g)1ii above;

(3) The part of the coverage that complies with (g)1ii above represents at least 50 percent of the benefits provided by the policy; and

(4) Any changes made after issue will meet the requirements in (g)2ii(1) through (3) above to ensure that compliance with (g)ii will be maintained.

3. A cash value or premium refund benefit may be included in disability income protection coverage if the following conditions are met:

i. The insurer must submit copies of sales or advertising literature and a statement of the class or type of insureds to whom the policy will be sold;

ii. The benefit is only included in a policy which is noncancellable or guaranteed renewable;

iii. The benefit payable is not reduced by an amount greater than the aggregate of claims paid under the policy;

iv. If the cash value or premium refund benefit depends on the policy being in force for a given term, and if the insured dies or otherwise terminates coverage prior to the end of the term, an appropriate benefit is provided. The benefit should be related to the number of years the cash value of premium refund provision has been in force and to the cash value or premium refund which would have been provided at the end of the given term. Some variation by issue age may be allowed.

4. A social insurance benefit may be included in disability income protection coverage if the following conditions are met:

i. Social insurance benefit is defined as a disability income benefit which is payable when the insured is not receiving disability benefits under government mandated programs including, but not limited to, Federal Social Security, Workers' compensation or occupational disability laws, automobile no-fault insurance;

ii. The amount payable for total disability is a fixed dollar amount;

iii. The insurer submits to the department the underwriting rules and benefit limits applicable to the benefit and any promotional material that will be presented to the proposed insured;

iv. Experience on policies that include the benefit is kept and reported separately from policies without the benefit.

(h) "Hospital confinement indemnity coverage" is a health insurance policy which provides daily benefits on an indemnity basis for a period of not less than 31 days during one period of hospital confinement for each person covered under the policy and which:

1. Provides a daily benefit of not less than \$40; and

2. Contains no elimination period greater than three days.

(i) "Accident only coverage" is a health insurance policy which provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismember-

ment amounts under such a policy shall be at least \$1,000 and a single dismemberment amount shall be at least \$500.

(j) "Medicare supplement coverage" is a health insurance policy sold to a Medicare eligible person, which is designed primarily to supplement Medicare, or is advertised, marketed, or otherwise purported to be a supplement to Medicare and which meets the minimum benefit standards and other requirements set forth in N.J.A.C. 11:4-23.

(k) "Limited benefit health coverage" is any health insurance policy which provides benefits that are less than the minimum standards for benefits required under N.J.A.C. 11:4-16.6(d), (e), (f), (g), (h), (i) and (j). Such policies may be delivered or issued for delivery in this State only if the outline of coverage required by N.J.A.C. 11:4-16.8(m) or (n) is completed and delivered as required by N.J.A.C. 11:4-16.8(b).

Amended by R.1988 d.453, effective September 19, 1988.
See: 20 N.J.R. 172(a), 20 N.J.R. 2377(b).

Deleted text from (d)1i and inserted new.

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).

Subsection (j) 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 (J)3.viii.: revised internal citations and references.

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

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

Added reference to "Medicare supplement policies" in (c)1.

Added "other requirements set forth in N.J.A.C. 11:4-23," in (j).

Deleted (j)1, 2, 3.

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.179, effective April 1, 1996.

See: 27 N.J.R. 3715(b), 28 N.J.R. 1881(c).

In (g) provided for noncomplying elimination periods.

11:4-16.7 Application forms

(a) Application forms shall not include provisions, statements or questions that:

1. Pertain to race, creed, color, national origin or ancestry of the proposed insured, except for hospital-medical insurance application forms for the purpose of collecting demographic data. No application form may include any provision or statement the effect of which is to discriminate against the proposed insured on the basis of race, creed, color, or national ancestry in a manner prohibited by law;
2. Change the terms of the policy to which it is attached;
3. State that the applicant has not withheld any information or concealed any facts; or
4. Require the applicant to agree that an untrue or false answer material to the risk shall render the contract void.

(b) If the insurer makes any changes or amendments to the application, signed acceptance by the applicant is required.

(c) Factual-type questions shall be used whenever possible to ascertain the past and present health of a proposed insured. If opinion-type questions are used, the application shall provide that the answers are stated to the best of the applicant's knowledge and belief.

(d) Questions concerning alcohol and drug abuse shall be based on specific criteria such as treatment, driving records, work attendance records, etc. Questions such as "Do you use alcohol or drugs to excess" shall not be used.

(e) Application forms shall include a means for identifying the coverage or policy for which application is made.

Amended by R.2005 d.365, effective November 7, 2005.

See: 37 N.J.R. 2291(a), 37 N.J.R. 4272(a).

Rewrote introductory paragraph of (a).

11:4-16.8 Required disclosure provisions

(a) General disclosure requirements are as follows:

1. Each individual policy of health insurance shall include a renewal, continuation, or nonrenewal provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

2. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder, exercises a specifically reserved right under the policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term, shall be agreed to in a written instrument signed by the insured, except if the increased benefits or coverage is required by law.

3. Where riders or endorsements which reduce or eliminate coverage are attached to the policy at issue, the policy shall contain on the first page or specification page either a prominent warning or the full text of the rider or endorsement.

4. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

5. The words "guaranteed renewable" shall not be used in a policy unless the insurer's right to change premium rates is clearly stated in the caption of the renewal provision or in the brief description of the policy.