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THE JOURNAL OF STATE AGENCY RULEMAKING

VOLUME 25 NUMBER 13
July 6, 1993 Indexed 25 N.J.R. 2795-3050
(Includes adopted rules filed through June 14, 1993)

MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: APRIL 19, 1993
See the Register Index for Subsequent Rulemaking Activity.

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Interested persons may submit comments, information or arguments concerning any of the rule proposals in this issue until **August 4, 1993.** Submissions and any inquiries about submissions should be addressed to the agency officer specified for a particular proposal.

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

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

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EXECUTIVE ORDERS

(a)

OFFICE OF THE GOVERNOR
Governor Jim Florio
Executive Order No. 95(1993)
State Officers and Employees
Blind Trusts and Interests in Closely Held Corporations

Issued: June 10, 1993.
Effective: June 10, 1993.
Expiration: Indefinite.

WHEREAS, since 1974 the New Jersey Executive Commission on Ethical Standards has had definitive rules for the establishment of blind trusts by State officers and employees; and

WHEREAS, Executive Order No. 1 (January 18, 1990) and Executive Order No. 9 (April 18, 1990) established strict financial disclosure requirements for public officers and employees of the State of New Jersey; and

WHEREAS, there is a need to continually evaluate existing standards in order to make them more responsive to the citizens we represent; and

WHEREAS, the highest possible level of disclosure is necessary in order to maintain the public's faith that their government is acting in the best interest of the citizenry; and

WHEREAS, such disclosure should allow the public to have knowledge of the assets and holdings of public officers and employees; and

WHEREAS, ownership in any closely held corporation that does business with government entities can raise the appearance of a potential conflict of interest;

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

I. Trusts

A. Blind trusts shall be eliminated in favor of full disclosure of assets by any regular State officer or employee (hereinafter "employee") or any special State officer or employee (hereinafter "officer"), *see* "Definitions," section V, *infra,* who is required by law or executive order to submit a financial disclosure statement to the Executive Commission on Ethical Standards.

B. After the date of this Order, no employee or officer who is required by law or executive order to submit financial disclosure statements to the Executive Commission on Ethical Standards ("Commission") shall maintain a blind trust. Furthermore, no such employee or officer shall establish a blind trust during that person's tenure.

C. The Commission shall immediately commence the process of terminating blind trusts held by any such employee or officer who is employed as of the date of this Order.

D. Any covered employee or officer who is employed as of the date of this Order shall forthwith notify the Commission as to the existence of a blind trust and the identity and address of the trustee. No later than June 30, 1993, the trustee shall advise the Commission of any and all assets held in such trust. The Commission shall review the assets and shall determine whether any such assets must be divested, consistent with the standards set forth in this Order. The Commission shall notify the trustee of its findings no later than August 15, 1993. The Commission shall afford the trustee 120 days after the date of notification to effectuate the orderly disposition of any such asset.

II. Interests in Closely Held Corporations or Similar Entities

A. No employee of a State agency who is required by law or executive order to submit financial disclosure statements to the Commission shall be permitted to retain any interest in any closely held corporation, partnership, sole proprietorship, or similar business entity doing business with any federal, state, interstate, or local government entity, except as provided in subsection 3 below.

1. Any such employee who is employed as of the date of this Order, and who retains any interest in any closely held corporation, partnership, sole proprietorship, or similar business entity doing business with any federal, state, interstate, or local government entity, shall notify the Commission as to his or her interest, and his or her spouse's interest, in such a business entity no later than June 30, 1993. The Commission shall review this disclosure statement to determine whether the business entities in which the employee has an interest are engaged in government-related business within the meaning of this Order, and whether the holdings are in compliance with the Conflicts of Interest Law and this Order. No later than August 15, 1993, the Commission shall notify the employee of its findings. The employee shall be afforded 120 days after the date of notification to effectuate the orderly disposition of any asset, or to demonstrate to the Commission that the business entity has ceased to do business with a government entity in a manner prohibited by this Order.

2. After the issuance of this Order, no State agency shall employ any person in a covered position who at the time of employment holds any interest in any closely held corporation, partnership, sole proprietorship, or similar business entity doing business with any federal, state, interstate, or local government entity, except as provided in subsection 3 below. No individual seeking employment in such a position shall divest a covered asset in a manner otherwise prohibited by this Order for the purpose of satisfying the provisions of this Order. Furthermore, no covered employee shall obtain any prohibited interest in a business entity during the employee's tenure.

3. The provisions of this subsection shall not apply to any purchase, sale, contract, or agreement with any government entity, other than a State agency, which is made or awarded after public notice and competitive bidding as provided by the Local Government Contracts Law, *N.J.S.A.* 40A:11-1 *et seq.,* or such similar provisions contained in the public bidding laws or regulations applicable to any government entity in this State or any other jurisdiction, provided that any such purchase, contract, agreement, or sale, including a change in orders and amendments thereto, shall receive the prior approval of the Commission. The provisions do apply where the purchase, sale, contract, or agreement is authorized by any of the exceptions (*e.g.,* professional or technical services, emergent matters, and unique compatibility) provided by the Local Government Contracts Law, *N.J.S.A.* 40A:11-1 *et seq,* or such similar provisions contained in the public bidding laws or regulations of any other jurisdiction.

B. No employee or officer who is required by law or executive order to submit a financial disclosure statement to the Commission shall retain any interest in any closely held corporation, partnership, sole proprietorship, or similar business entity unless the Commission shall have first determined that the employee or officer may retain such an interest in such business entity.

1. Each covered employee or officer who is employed or appointed as of the date of this Order shall notify the Commission as to his or her interest, and his or her spouse's interest, in any such business entity no later than June 30, 1993. The Commission shall review the disclosure statement and shall determine whether the employee or officer may retain such interest in the business entity consistent with the standards set forth in the Conflicts of Interest Law and this Order. The Commission shall notify the employee or officer of its findings no later than August 15, 1993. The employee or officer shall be afforded 120 days after the date of notification to effectuate the orderly disposition of any asset or to demonstrate that the business entity has ceased the business activity in question.

2. After the issuance of this Order, no State agency shall employ or appoint any employee or officer to a covered position if such person holds any interest in any closely held corporation, partnership, sole proprietorship, or similar business entity, unless the Commission has reviewed such interest and determined that the employee or officer may retain such an interest. A person seeking such employment or appointment shall disclose to the Commission his or her interest, and his or her spouse's interest, in any such business entity as soon as practicable, and the Commission shall render a determination no later than thirty days after receiving such disclosure, or at its next regularly scheduled meeting. No individual seeking employment or appointment to such a position shall divest a covered asset in a manner otherwise prohibited by this Order for the purpose of satisfying the provisions of this Order.

III. Ongoing Review by the Commission

A. The Commission shall review all financial disclosure statements as they may from time to time be submitted by covered employees and

officers to determine whether the covered persons have obtained ownership or interest in any assets that give rise to a present or potential conflict of interest, or a present or potential appearance of a conflict of interest, within the meaning of this Order.

B. Each covered employee or officer shall amend his or her financial disclosure statement within thirty days of gaining knowledge of (a) his or her, or his or her spouse's acquisition of any interest in any closely held corporation, partnership, sole proprietorship, or similar business entity; or (b) the commencement of any business activity covered by the provisions of this Order and as determined by the Commission, including, for example, a change in business plan authorizing business activity with a federal, state, interstate, or local government entity, by a business in which the employee or the employee's spouse has an interest covered by this Order.

C. Any employee or officer subject to this Order who acquires an interest prohibited under this Order by way of inheritance, bequest, or similar circumstance beyond his or her control shall follow the procedures for disclosure and disposition set forth in Section II of this Order.

IV. Limitations on Divestiture

A. All required divestitures shall be subject to the following conditions:

1. Divestiture must occur within the time periods prescribed above.

2. Ownership or control of the asset may not be transferred to a member of the employee's or officer's immediate family (*see* "Definitions," section V, *infra*).

3. The terms and conditions of any conveyance of ownership and control of the asset shall not contain any provisions regarding the return of the asset to the employee or officer subsequent to his or her State services.

V. Definitions

A. For the purpose of this Order:

1. "Member of the immediate family" shall mean a spouse, child, parent, or sibling residing in the same household.

2. "Asset" shall mean property of any kind, real and personal, tangible and intangible, having a value greater than $1,000.

3. "Interest" in a closely held corporation, partnership, sole proprietorship, or similar business entity shall mean any ownership or control of any profits or assets of such business entity.

4. "Doing business" with any federal, state, or local government entity shall mean business or commercial transactions involving the sale, conveyance, or rental of any goods or services, and shall not include such activities as compliance with regulatory procedures.

5. "Regular State employee" shall have the same meaning as "State officer or employee" as set forth at *N.J.S.A.* 52:13D-13b, and "special State officer" shall have the same meaning as "Special State officer or employee" as set forth at *N.J.S.A.* 52:13D-13e.

6. "State agency" shall mean any of the principal departments of State government and any entity allocated therein in conformance with *N.J. Const.* (1947), Art. V, §IV, para. 1.

VI. Sanctions and Effective Date

A. The failure of an employee or officer to comply with the provisions of this Order shall constitute good cause for his or her removal from employment or office.

B. This Order shall take effect immediately.

(a)

OFFICE OF THE GOVERNOR
Governor Jim Florio
Executive Order No. 96(1993)
Tribute to Mildred Barry Garvin

Issued: June 15, 1993.
Effective: June 15, 1993.
Expiration: Indefinite.

WHEREAS, Mildred Barry Garvin zealously served the citizens of Essex County as the first African American on the East Orange Board of Education, rising to be president of that body; and

WHEREAS, she was also the first African American to serve on the East Orange Public Library's Board of Directors, holding the post of Secretary/Treasurer; and

WHEREAS, she moved on to serve in the General Assembly from 1967-77, chairing the Education Committee; and

WHEREAS, her commitment to education remained steadfast throughout her career serving Rutgers University as Director of Special Projects and Internships in the Department of Public Administration; and

WHEREAS, she received numerous awards, citations, and testimonials honoring her entrepreneurial spirit and dedication, including the State Family Planning Legislator's Recognition Award in 1985, the Mary Senatore Award from the Essex County Federation of Democratic Women, the Community Service Award from the Oranges and Maplewood Branch of the NAACP, and an Exemplary State Officials Award from the Morris County Chapter of the Association of Black Educators; and

WHEREAS, her inspiring career was crowned in 1991 when she was sworn in as President of the NAACP of the Oranges and Maplewood; and

WHEREAS, it is fitting and appropriate for the State of New Jersey to mark the passing of Mildred Barry Garvin, a standard bearer and public servant;

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

1. The flag of the United States of America and the flag of the State of New Jersey shall be flown at half staff at all State departments, offices, agencies and instrumentalities during appropriate hours beginning on Tuesday, June 15, 1993, through and including Wednesday, June 16, 1993 in recognition and mourning of the passing of a distinguished legislator and New Jersey citizen, Mildred Barry Garvin.

2. This Order shall take effect immediately.

RULE PROPOSALS

BANKING

(a)

DIVISION OF REGULATORY AFFAIRS

Conversion of Associations

Proposed Readoption: N.J.A.C. 3:32

Authorized By: Jeff Connor, Commissioner, Department of Banking.
Authority: N.J.S.A. 17:12B-1 et seq.
Proposal Number: PRN 1993-372.

Submit comments by August 4, 1993 to:
Steve Szabatin, Deputy Commissioner
Department of Banking
CN 040
Trenton, N.J. 08625

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 3:32, Conversions of Associations, expires on October 3, 1993. The Department of Banking has reviewed the rules initially adopted October 3, 1988 and amended June 17, 1991, and has determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated, as required by the Executive Order.

Subchapter 1 provides, consistent with Article XXI of the Savings and Loan Act (1963) as amended and N.J.S.A. 17:12B et seq., the procedure by which an insured mutual association may convert to a capital stock association. Applications and other forms provided by and filed with the Federal Savings and Loan Insurance Corporation shall be forwarded to the Commissioner as part of the application process for preliminary approval, together with the required fee. A 3121 Association may comply by submitting the form provided by the Commissioner.

Subchapter 1 also requires a State chartered association making such conversion to comply with certain specified conditions and procedures. An association applying for conversion must adopt a resolution to this effect, approved by two-thirds of the board of directors. In addition the plan must be fair and equitable to all members and include sufficient provision to protect the interest of the depositors of the prospective capital stock association. If the Commissioner approves the preliminary application, he or she shall issue an intent of approval which is subject to the affirmative vote of a majority of eligible members and compliance with applicable law.

Subchapter 1 also sets forth parameters for members' entitlement to vote, times when special meetings may be called and manner in which voting may take place concerning conversion, adoption of bylaws and election of officers, in person or by proxy. In addition this subchapter defines persons eligible to purchase shares of stock, price of stock and designates qualifications for independent persons who will establish prices. A definition of "3121 Association" is provided, as well as the standard applied by the Commissioner for approval of the application for conversion.

Subchapter 2 requires the savings bank or association applying to convert to submit the following: (1) a certified copy of the resolution of the board of directors authorizing the conversion; (2) a certified copy of the resolution adopted by the stockholders or members; (3) a certificate of incorporation for the converted institution; (4) biographical information; (5) completed requests for criminal history information; (6) a copy of the institution's most recent quarterly financial report; (7) financial projects for the next three years; and (8) copies of all applications for Federal regulatory approval and all approvals required in connection with the conversion, or a statement or opinion of counsel for the savings bank or association that no Federal regulatory approvals are required.

In addition, the applicant must submit a nonrefundable application fee. This fee is set at $10,000. The Department is presently considering a rule which would limit the fee to $10,000 in those circumstances where an institution initiates a second conversion after completion of an initial conversion.

Social Impact

Readoption of these rules will continue to provide a mechanism for conversion of associations to savings banks and from savings banks to associations. Upon such conversion, the depository will remain in place with no adverse impact upon the community it serves.

Economic Impact

The proposed readoption makes no change in the previously established fee for conversions at $10,000. Such fee will have a negative effect on the depository. This fee is necessary to reimburse the Department for the administrative costs of reviewing the application.

However, associations which convert to savings banks for the first time will be able to avoid costs associated with duplicative regulation by the Office of Thrift Supervision, so these institutions will sustain a positive economic impact as a result of the rules.

Regulatory Flexibility Analysis

The rules proposed for readoption impose compliance requirements on savings banks and associations applying for conversion. In particular, the proposed rules require a converting institution to file several items with the Department. Approximately one-half of these institutions are small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. It is essential that the Department receive this information from all converting institutions so that it may review compliance with statutory requirements. In addition, the information permits the Department to review the soundness of the institution and the competence of its management. This review is necessary for all institutions, so no differentiation is made based on the size of the institution.

The proposed readoption also continues imposition of the $10,000 application fee. This fee reimburses the Department for its administrative costs for reviewing the application. These costs are incurred regardless of the size of the depository. Accordingly, no differentiation is made here either.

Full text of the proposed readoption can be found in the New Jersey Administrative Code at N.J.A.C. 3:32.

ENVIRONMENTAL PROTECTION AND ENERGY

(b)

DIVISION OF PARKS AND FORESTRY

State Park Service Code

Proposed Amendments: N.J.A.C. 7:2-2.20, 3.6, 6.4, 8.4, 8.6, 10.2, 16.5, 17.1, 17.3, 17.4 and 17.5

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.
Authority: N.J.S.A. 13:1B, 13:1B-15.100 et seq., and 13:1L-1 et seq.
DEPE Docket Number: 37-93-06.
Proposal Number: PRN 1993-361.

Submit comments by August 4, 1993 to:
Janis Hoagland, Esq.
Administrative Practice Officer
Office of Legal Affairs
Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625-0402

The agency proposal follows:

Summary

The State Park Service Code, adopted on September 4, 1991, at N.J.A.C. 7:2, governs the administration, management and use of State parks, forests, recreational areas, historic sites, natural areas, marinas, golf courses, botanical gardens and other lands, waters and facilities under the jurisdiction of the Department and assigned to the State Park Service in the Division of Parks and Forestry.

The proposed amendments concerning the adjustment of fees charged for services and facilities provided by the State Park Service and including correction of a number of typographical errors and minor clarifications are as follows:

The proposed amendment at N.J.A.C. 7:2-2.20(c) requiring that a person under 12 years of age shall not be admitted to the swimming pool at Liberty State Park unless the person is accompanied by a person at least 18 years of age is intended to ensure the health, safety and welfare of the children using the pool.

The proposed amendment to N.J.A.C. 7:2-3.6(b) clarifies the restricting of the speed limit for motor vehicles on improved (dirt, gravel or sand) roadways to 20 miles per hour unless otherwise posted. The amendment clarifies that the restricted speed limit applies to unimproved (dirt, gravel or sand) roadways.

The Code now restricts the occupancy of a campsite by one party to 14 consecutive days and a total maximum of 40 days in any calendar year. The amendments clarify that the restriction is counted by the number of nights not days. (N.J.A.C. 7:2-6.4(a)1, 2, 3 and 4).

The Code now gives preference to New Jersey residents for the reservation of cabins and camp shelters. In accordance with the Federal "Land and Water Conservation Fund Act," section 6(f)(8), and 36 CFR 59.4, this discrimination on the basis of residence is prohibited. Therefore all references to residential preference in the codified reservation procedures (N.J.A.C. 7:2-7.2(a) and (b)) have been deleted. This preference was initiated over 35 years ago, when neighboring states had not yet developed their cabin facilities and New Jersey residents were being shut out due to the great number of out-of-state reservation requests. Since that time, both New York and Pennsylvania have developed their cabin and shelter facilities, which has resulted in New Jersey facilities being utilized, on average, only 58 percent of the time during fiscal year 1992.

The Code currently prohibits the use of sailboats and ice sailboats on the Round Valley and Spruce Run Reservoirs with masts higher than 30 feet. The Code is amended to include the Monksville Reservoir and to clarify that the mast height is measured from the water line. (N.J.A.C. 7:2-8.4). The restriction on mast height of greater than 30 feet from the water line at Round Valley, Spruce Run Recreation Area and Monksville Reservoirs is a direct result of the high tension/voltage power lines that hang and extend across these bodies of water. Any contact with these wires by any item would expose the individual(s) to great risk and possible harm.

The Code now prohibits the use of wind surfboards within 50 feet of a designated bathing area. The word "wind" is proposed for deletion to clarify that the prohibition applies to surfboards. (N.J.A.C. 7:2-8.6(b)).

The Code currently allows golf course starting time reservations. The proposed amendment eliminates reservations except for tournaments and provides that golf course play is on a first-come first-serve basis. (N.J.A.C. 7:2-10.2(a) and (b)). The elimination of the reservation of golf course starting times is intended to allow the maximum number of people a fair and equitable opportunity to enjoy golf at all hours when the course is open.

The Code now provides that Island Beach State Park shall be closed to all persons except Mobile Sport Fishing Vehicle (MSFV) permit holders and persons surf fishing after 8:00 P.M. The Code is amended to clarify that not just persons actively surf fishing but surf fishermen and Barnegat Bay Waterfowl hunters may remain after 8:00 P.M. (N.J.A.C. 7:2-16.5). The proposed inclusion of the Barnegat Bay Waterfowl hunters in the group of users that may remain at Island Beach State Park after 8:00 P.M. recognizes a continuing use that was omitted from the Code by mistake.

All parking and walk-in fees as well as yearly State Park passes are no longer applicable at Barnegat Lighthouse State Park and are proposed to be deleted as a result of the construction of a new South Jetty which no longer permits day-use bathing. The only applicable fee ($1.00) is for the entrance to the lighthouse proper (N.J.A.C. 7:2-17.1(a)3 and (e)ii). Proposed new N.J.A.C. 7:2-17.1(n) provides for the charging of a fee of $1.00 for admission to the Barnegat Lighthouse for all people 12 years of age and over from Memorial Day weekend and ending on Labor Day.

The Code is amended to include a fee of $500.00 for use of the Terminal Building at Liberty State Park for a half day (four hours or less) for each event; the Code is further clarified to provide that the daily fee is charged for any part of a day greater than four hours. The use of the Terminal Building has increased dramatically over the past several years, especially for commercial photography and commercial production advertising promotion. The Department failed to provide a fee schedule for less than a full day's use (half day). This omission has resulted in a loss of revenue from those people who need to use the Terminal Building for less than one day. (N.J.A.C. 7:2-17.3(e)2 and 3).

The Code is amended to revise the nautical terms and marina fee charge descriptions in the Code to be consistent with the terms and descriptions currently in use by boat owners and marina operators. The proposed corrections have no impact on the public and will help eliminate problems in interpreting the Code. (N.J.A.C. 7:2-17.4(a)2i and ii).

In order for the Department to control the administration and management of the State parks, forests, recreational areas, historic sites, natural areas, golf courses, botanical gardens and other lands, waters and facilities under its jurisdiction in a manner that encourages public use, the Department must have the ability to not only increase the fees charged for use of the services and facilities provided by the State Park Service but to decrease any or all of such fees where the Department determines that a fee decrease is necessary to encourage public use and will not result in a reduction of the services and facilities available to the public. The proposed amendment to N.J.A.C. 7:2-17.5(d) allows the Department to decrease the fees charged under N.J.A.C. 7:2-17.1, 17.2, 17.3 and 17.4 for use of services and facilities provided by the State Park Service upon publication of a notice of the decreased fees in the New Jersey Register. The Code is amended to provide that fees that have been reduced under N.J.A.C. 7:2-17.5(d) may be increased in any amount by the Department upon publication of a notice of increase in the New Jersey Register provided the fee is not increased above the fee for said service or facility set forth in N.J.A.C. 7:2-17.1, 17.2, 17.3 and 17.4 (N.J.A.C. 7:2-17.5(e)).

Social Impact

The proposed amendments provide a positive social impact by clarifying the Code to increase public use of and to assure the continued availability of the services and facilities provided by the State Park Service. The proposed amendments also refine the application of the Code concerning the regulation of the use of lands and waters under the jurisdiction of the Department and assigned to the State Park Service in the Division of Parks and Forestry for the protection of the natural and historic resources and improvements thereon and for the safety, protection and general welfare of the public. The proposed amendments ensure that public use of the natural and historic resources under the jurisdiction of the State Park Service occurs in areas managed for such purposes and under conditions intended to protect such resources and the public.

Economic Impact

The Code includes a schedule of fees, N.J.A.C. 7:2-17, for the services and facilities provided by the State Park Service such as, but not limited to, parking, boat launching, campsites, cabins and golf courses, in accordance with N.J.S.A. 13:1L-19.

The primary economic impact of the proposed amendments is the fee for use of the Terminal Building at Liberty State Park for a half day or less, and the procedure for the reduction of fees set forth in N.J.A.C. 7:2-17.1, 17.2, 17.3 and 17.4 upon publication of a notice in the New Jersey Register.

The Department recognizes that the proposal to establish a half day fee for use of the Terminal Building represents an economic impact to the public. However, these fees were previously established to offset the cost of providing the services and facilities to the public without the ability to charge for a half day rate where applicable.

The proposed fee reduction procedure will have the positive economic impact of reducing the direct cost to the public for the use of services and facilities provided by the State Park Service when the Department determines that a fee decrease is necessary to encourage public use and will not result in a reduction in the services and facilities available to the public.

Environmental Impact

The proposed amendments will provide a positive environmental impact by ensuring proper administration, management and regulation of State parks, forests, recreational areas, historic sites, natural areas, marinas, golf courses, botanical gardens and other lands, waters and facilities under the jurisdiction of the State Park Service and permitting only those uses, in accordance with the proposed rules and amendments, that will be in the best interest of the conservation and preservation of the natural and historic resources and the best interest of the health, safety and general welfare of the public.

Regulatory Flexibility Statement

The purpose of the proposed amendments is to clarify the aspects of and regulate the general public's use of all State parks, forests, recreational areas, natural areas, historic sites, marinas, golf courses, botanical gardens and other lands, waters and facilities under the jurisdiction of the Department and assigned to the State Park Service in the Division of Parks and Forestry. Accordingly, the Department has determined, pursuant to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., that the proposed amendments will impose no reporting, recordkeeping or other compliance requirements upon small businesses. Therefore, no regulatory flexibility analysis is required.

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

7:2-2.20 Swimming/bathing areas

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

(c) A person under the age of 12 years shall not be admitted to the swimming pool at Liberty State Park unless the person is accompanied by a person [12] **18** years of age or older.

(d)-(i) (No change.)

7:2-3.6 Motor vehicle speed limits

(a) (No change.)

(b) A person shall not travel by motor vehicle on [improved] **unimproved** (dirt, gravel or sand) roadways at a speed greater than 20 miles per hour unless otherwise posted higher or lower.

7:2-6.4 Time limits: overnight camping

(a) In order to afford the public the greater possible use of the State Park Service camping system, continuous occupancy by the same persons or equipment of any camping site is limited as follows:

1. A person or persons shall not occupy a campsite for more than 14 consecutive [days] **nights**.

2. A person or persons who have occupied a campsite for an initial 14 [day] **night** limit shall not re-register until seven calendar [days] **nights** have elapsed.

3. Additional camping shall be permitted in intervals up to, but no more than, seven [days] **nights** at a time with a minimum of seven calendar [days] **nights** out-time required between each occupancy.

4. The total maximum camping [days] **nights** in any calendar year shall not exceed 40 [days] **nights**.

7:2-7.2 Overnight facilities reservation procedures

(a) All applications for reservations of cabins and camp shelters shall be submitted on forms available from the State Park Service. Applications shall be accepted if postmarked or received after January 2nd of the year in which the facilities are to be used. [Residents of New Jersey shall have their applications acted upon on a first-come first-serve basis or a lottery system of selection, if the demand dictates.] Reservations shall not be made by telephone.

(b) [After the applications by New Jersey residents have been satisfied, out-of-state residents' applications] **Applications** shall be acted upon on a first-come first-serve basis or a lottery system of selection, if the demand dictates. All applications received after this process is completed shall be acted upon as received.

(c)-(k) (No change.)

7:2-8.4 Sailboats and ice sailboats mast[s] height on the Round Valley [and], Spruce Run **and Monksville** Recreation Reservoirs

A person shall not operate a sailboat or ice sailboat with a mast height of greater than 30 feet **from the water line** on the Round Valley [or], Spruce Run **and Monksville Recreation Reservoirs**.

7:2-8.6 Boating near bathing areas

(a) (No change.)

(b) A person shall not operate human powered slow moving watercraft such as rowboats, pedal boats, canoes, [wind] surfboards, or any other water borne mechanisms meeting this definition within 50 feet of a designated bathing area.

7:2-10.2 Reservations—golf course

(a) Golf course [reservations shall be accepted by telephone only and are] **play is** on a first-come, first-serve basis **only, except as provided in (b) below.**

[(b) Starting time reservations shall be accepted on Thursday after 12:00 noon for weekend and holiday play.]

[(c)](**b**) Tournament reservations shall be made 30 days in advance and are not effective until confirmed in writing by issuance of a special use permit by the State Park Service.

1.-3. (No change.)

7:2-16.5 Island Beach State Park

(a) Island Beach State Park shall be closed to all persons, excepting MSFV permit holders [and persons surf fishing,] **surf fishermen and Barnegat Bay waterfowl hunters** between 8:00 P.M. and 8:00 A.M. from April 1 through October 31 and betwen 8:00 P.M. and 5:00 A.M. from November 1 through March 31 annually.

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

7:2-17.1 Day use fees for services and facilities provided by the State Park Service

(a) Except as provided in (i) below, daily parking fees for automobiles at designated State parks, for the period beginning with Memorial Day weekend and ending on Labor Day inclusive, are as follows:

AREA	WEEKDAYS	WEEKENDS AND HOLIDAYS
1. Allaire	$4.00	$5.00
2. Atsion	$5.00	$7.00
[3. Barnegat Lighthouse	$5.00	$7.00]

Recodify existing 4.-21. as **3.-20.** (No change in text.)

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

(e) The daily or annual walk-in and bicycle fee for persons 12 years old and above at designated State parks, forests and recreation areas is as follows:

1. AREA	DAILY FEE	ANNUAL WALK-IN AND BICYCLE PASS
i. Atsion	$1.00	$35.00
[ii. Barnegat Lighthouse	$1.00	$35.00]

Recodify existing iii.-vii. as **ii.-vi.** (No change in text.)

2. An annual walk-in and bicycle pass purchased at one of the State parks, forests and recreation areas listed in (e)1 above shall be honored for walk-in and bicycle admittance at any of the designated State Parks, forests and recreation areas.

(f)-(k) (No change.)

(l) Except when parking fees are in effect pursuant to (a) and (c) above, a fee of $1.00 for each person age 12 and over shall be charged for admission to the [Barnegat Lighthouse and] High Point Monument.

(m) (No change.)

(n) The daily fee per person for admission to the Barnegat Lighthouse will be $1.00 for each person age 12 and over for the period beginning Memorial Day weekend and ending on Labor Day.

7:2-17.3 Miscellaneous fees for services when and where provided by the State Park Service

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

(e) Miscellaneous fees for services provided by the State Park Service at Liberty State Park are as follows:

	Service	Fee
1.	Fee for use of Interpretive Center	$40.00/hour for each State Park Service employee assigned
2.	Fee for use of Terminal Building **for a day or part of a day longer than four hours**	$1,000/day for each event
3.	**Fee for use of Terminal Building for a half day (four hours or less)**	**$500.00/half day for each event**
[3.]**4.**	Boat docking fee for one arrival and one departure	$250.00
[4.]**5.**	Fee for use of North or South Field	$250.00/event

7:2-17.4 Fees for services provided by the State Park Service at State marinas

(a) Fees for services provided by the State Park Service at the Forked River State Marina are as follows:

1. (No change.)
2. Transient berthholder fee:

	[Berth] **Vessel** Size	Daily	Monthly
i.	[Thirty feet through 40 feet] **Forty feet and under**	$0.75/foot length overall	$15.00/foot length overall;
ii.	[Forty-five feet through over 50 feet] **Forty-one feet and longer**	$1.00/foot length overall	$20.00/foot length overall; and

iii. T-Head and dockside fee equal to corresponding berth size rate; and

3. (No change.)

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

7:2-17.5 Adjustment of fees for services and facilities provided by the State Park Service

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

(d) The Department may establish fees for services and facilities that are lower than the fees set forth in N.J.A.C. 7:2-17.1, 17.2, 17.3 and 17.4 for said services or facilities by publishing a fee reduction notice in the New Jersey Register. The fee reduction shall be based on a determination by the Department that the fee reduction is necessary to encourage public access to and use of the service and facilities provided by the State Park Service and will not result in a reduction of the services and facilities available to the public. The reduced fees shall be effective upon publication of the fee reduction notice in the New Jersey Register.

(e) Fees for services and facilities provided by the State Park Service that have been reduced in accordance with (d) above may be increased in any amount by the Department upon publication of a notice of increase in the New Jersey Register provided the fee is not increased above the fee set forth in N.J.A.C. 7:2-17.1, 17.2, 17.3 or 17.4 for the service or facility.

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

HEALTH

(a)

DRUG UTILIZATION REVIEW COUNCIL
List of Interchangeable Drug Products
Proposed Readoption: N.J.A.C. 8:71

Authorized By: Drug Utilization Review Council, Henry T. Kozek, Secretary.
Authority: N.J.S.A. 24:6E-1(a).
Proposal Number: PRN 1993-368.

The agency proposal follows:

Summary

In 1977, N.J.S.A. 24:6E-6 et seq. directed the establishment of the Drug Utilization Review Council (Council), whose duty it was to prepare a list of generic drug products which could be safely substituted for brand name prescription products, thus saving money for consumers.

N.J.S.A. 24:6E-1(a) authorized the Council to prepare a list of interchangeable drug products. The list was to contain the names of drug manufacturers whose products were judged by the Council to be therapeutically equivalent to brand name prescription drugs.

The intent of the legislation was to dictate circumstances under which one of the therapeutically equivalent generic products would be substituted for the brand name drug which a prescriber had ordered, thus saving money for the consumer. N.J.A.C. 8:71 lists all of the branded medications which are also substituted for, under specified conditions, and also lists all of the acceptable generic manufacturers. Without the list, implementation of N.J.S.A. 24:6E-1 et seq. would be impossible.

The List of Interchangeable Drug Products has been effective in saving money for consumers as outlined under the Economic Impact statement below.

The Drug Utilization Review Council (the Council), in the Department of Health, proposes to readopt N.J.A.C. 8:71 without change. The Council has reviewed these rules and has determined that they are necessary, reasonable, and proper for the purpose for which they were originally promulgated. Public comment is invited so that the Council can make a fully informed decision as to whether these rules should be readopted before their expiration date, pursuant to Executive Order No. 66(1978) on February 17, 1994.

Social Impact

The Council believes that this readoption will continue the positive social impact that these rules have had in the past; the elderly, those persons with limited incomes, and any interested citizen will continue to be assured of reasonably priced generic substitutes for brand name drugs.

Health Department studies have shown that, although over 40 percent of prescribers disallow generic substitution, fewer than five percent of consumers disallow such substitution, thus demonstrating consumer acceptance.

An increased impact of generic substitution is expected in the future based on three factors; an increased number of elderly, who use a disproportionate number of medicines, in the population; more brand name drugs coming out from under patent protection: and an increased emphasis on reducing the cost of health care without effecting quality.

In the last five years, generic substitution has increased, from approximately five million New Jersey prescriptions substituted in 1984, to an estimated 10 million in 1992. If the List of Interchangeable Drug Products were not to be readopted, generic substitution would falter, resulting in lessened access to generic medicines for all New Jersey consumers.

Economic Impact

The Council believes that readoption of the List of Interchangeable Drug Products will serve to continue to exert a positive economic impact, not only on these groups mentioned under the Social Impact statement above, but on several State programs that pay for medications, such as the PAAD Program, the Medicaid Program, and the prescription insurance program available to State employees.

A 1992 Drug Utilization Review Council survey of 10,000 prescriptions from 100 randomly-selected pharmacies has estimated that the Statewide total of all savings due to the use of generic substitutes approximates at least $100 million annually, based on a savings averaging $10.00 each for an estimated 10 million substituted prescriptions.

Regulatory Flexibility Analysis

The readopted List of Interchangeable Drug Products will continue to impact several dozen generic drug manufacturers which employ fewer than 100 employees. However, their limited recordkeeping requirements or other paperwork to be completed under these rules are more than offset by expanded sales made possible thereunder. Therefore, the Department will not exempt any business from compliance with these rules.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 8:71.

(b)

DRUG UTILIZATION REVIEW COUNCIL
List of Interchangeable Drug Products
Proposed Amendments: N.J.A.C. 8:71

Authorized By: Drug Utilization Review Council, Henry T. Kozek, Secretary.
Authority: N.J.S.A. 24:6E-6(b).
Proposal Number: PRN 1993-369.

A **public hearing** concerning these proposed amendments will be held on Monday, July 26, 1993, at 2:00 P.M. at the following address:

Room 804, Eighth Floor
Department of Health
Health-Agriculture Bldg.
Trenton, New Jersey 08625-0360

Submit written comments by August 4, 1993 to:
Mark A. Strollo, R.Ph., M.S.
Drug Utilization Review Council, Room 501
New Jersey Department of Health
CN 360
Trenton, N.J. 08625-0360
609-292-4029

The agency proposal follows:

Summary

The List of Interchangeable Drug Products is a generic formulary, or list of acceptable generic drugs which pharmacists must use in place of brand-name prescription medicines, passing on the resultant savings to consumers.

For example, the proposed clindamycin phosphate 1% topical solution could be used as a less expensive substitute for Cleocin T, a branded prescription medicine. Similarly, the proposed metoprolol tartrate 50 mg and 100 mg tablets, could be substituted for the more costly branded product, Lopressor.

The Drug Utilization Review Council is mandated by law to ascertain whether these proposed medications can be expected to perform as well as the branded products for which they are to be substituted. Without such assurance of "therapeutic equivalency," any savings would accrue at a risk to the consumer's health. After receiving full information on these proposed generic products, including negative comments from the manufacturers of the branded products, the advice of the Council's own technical experts, and data from the generics' manufacturers, the Council will decide whether any of these proposed generics will work just as well as their branded counterparts.

Every proposed manufacturer must attest that they meet all Federal and State standards, as well as having been inspected and found to be in compliance with the U.S. Food and Drug Administration's regulations.

Social Impact

The social impact of the proposed amendments would primarily affect pharmacists, who would need to either place in stock, or be prepared to order, those products ultimately found acceptable.

Many of the proposed items are simply additional manufacturers for products already listed in the List of Interchangeable Drug Products. These proposed additions would expand the pharmacist's supply options.

Physicians and patients are not adversely affected by this proposal because the statute (N.J.S.A. 24:6E-6 et seq.) allows either the prescriber or the patient to disallow substitution, thus refusing the generic substitute and paying full price for the branded product.

Economic Impact

The proposed amendments will expand the opportunity for consumers to save money on prescriptions by accepting generic substitutes in place of branded prescriptions. The full extent of the saving to consumers cannot be estimated because pharmacies vary in their prices for both brands and generics.

Some of the economies occasioned by these amendments accrue to the State through the Medicaid, Pharmaceutical Assistance to the Aged and Disabled Program, and prescription plan for employees. A 1988 estimate of average savings per substituted Medicaid prescription was $7.31. However, the number of prescriptions that will be newly substituted due to these proposed amendments cannot be accurately assessed in order to arrive at a total savings.

Regulatory Flexibility Analysis

The proposed amendments impact many small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. specifically, over 1,500 pharmacies and several small generic drug manufacturers which employ fewer than 100 employees.

However, there are no reporting or recordkeeping requirements for pharmacies, and small generic drug manufacturers have minimal initial reports, and no additional ongoing reporting or recordkeeping requirements. Further, these minimum requirements are offset by the increased economic benefits accruing to these same small generic businesses due to these proposed amendments.

Full text of the proposed amendments follows:

Albuterol sulfate syrup 2mg/5ml	Watson
Alprazolam tabs 0.25mg, 0.5mg, 1mg	Geneva
Alprazolam tabs 0.5mg	Lederle
Atenolol tabs 50 mg, 100 mg	Genpharm
Benzonatate caps 100 mg	Scherer
Carbidopa/levodopa tabs 10/100, 25/100, 25/250	Watson
Clindamycin phosphate topical soln 1%	Copley
Cyclobenzaprine tabs 10 mg	West Point
Desipramine HCL tabs 25mg, 50mg, 75mg, 100mg	Eon
Fluphenazine decanoate injection 25mg/ml	Lyphomed
Fluphenazine HCL exlixir 0.5mg/ml	Copley
Fluphenazine HCL injection 2.5mg/ml	Lyphomed
Hydroxyzine pamoate caps 25mg, 50mg	Eon
Imipramine HCL tabs 10mg, 25mg, 50mg	Eon
Indapamide tabs 2.5mg	Arcola
Indomethacin caps 25 mg, 50 mg	West Point
Indomethacin ER caps 75 mg	West Point
Isoxsuprine HCL tabs 10 mg, 20 mg	Eon
Levothyroxine sodium tabs 25mcg, 50mcg	Rhone-Poulenc Rorer
Levothyroxine sodium tabs 75mcg, 100mcg	Rhone-Poulenc Rorer
Levothyroxine sodium tabs 125mcg, 150mcg	Rhone-Poulenc Rorer
Levothyroxine sodium tabs 175mcg, 200mcg	Rhone-Poulenc Rorer
Levothyroxine sodium tabs 300 mcg	Rhone-Poulenc Rorer
Lidocaine HCL jelly 2%	Copley
Medroxyprogesterone acetate tabs 2.5mg, 5mg, 10mg	Ayerst
Medroxyprogesterone acetate tabs 2.5mg, 5mg, 10mg	Greenstone
Meprobamate tabs 200 mg	Eon
Metoprolol tartrate tabs 50mg, 100mg	Danbury
Naproxen tabs 250 mg, 375 mg, 500 mg	Copley
Naproxen tabs 500 mg	Genpharm
Naproxen tabs 500 mg	Mutual
Novahistine DH elixir substitute	Barre-Nat'l
Nystatin cream 100,000u/gm	Taro
Pergonal injection substitute 75IU, 150IU	Lederle
Robitussin AC syrup substitute	Barre-Nat'l
Sulindac tabs 150 mg, 200 mg	West Point
Sulindac tabs 150 mg, 200 mg	Mylan
Tetracycline HCL caps 250 mg	Eon
Tolmetin sodium capsules 400 mg	Mylan

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Home Care Services Manual

General Provisions, Home Care Community Based Service Programs, Home Care Expansion Program (HCEP), HCFA Common Procedure Coding System (HCPCS) Appendix A, Fiscal Agent Billing Supplement

Proposed Amendments: N.J.A.C. 10:60-1.2, 2.2, 2.4, 2.5, 2.8, 2.9, 2.10, 2.12, 2.14, 2.15, 2.16, 3.2, 3.3, 3.6 and 4.2

Proposed New Rules: N.J.A.C. 10:60-1.3 through 1.17

Proposed Repeal and New Rule: N.J.A.C. 10:60-1.1

Proposed Repeals: N.J.A.C. 10:60-2 and 6, Appendices A through H

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

Authority: N.J.S.A. 30:4D-6b(2), 7, 7a, b and c; 30:4D-12; 30-4E; 42 CFR 440.70, 170(F) and Section 1902(w) of the Social Security Act, 42 U.S.C. 139a.

Agency File Number: 93-P-8.

Proposal Number: PRN 1993-337.

Submit comments by August 4, 1993 to:
Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance and Health Services
CN 712
Trenton, New Jersey 08625-0712

The agency proposal follows:

Summary

N.J.A.C. 10:60 became effective on February 19, 1991, for a period of five years which expires on February 19, 1996. For the sake of clarity, the Department of Human Services is proposing that N.J.A.C. 10:60 be amended and recodified in order to incorporate the following changes in language, format and organization of material, so that home care providers can more effectively utilize the manual in the delivery of services.

The Home Care Services Manual includes information about home health services, personal care assistant services, Home and Community-based Waiver Services Programs and the Home Care Expansion Program. Providers eligible to participate in those home care programs include home health agencies, homemaker agencies, hospice agencies and private duty nursing agencies.

Proposed revisions to the Home Care Services Manual include the following:

1. Proposed N.J.A.C. 10:60-1.1 is all new and outlines the applicability of the Home Care Services Manual, N.J.A.C. 10:60. N.J.A.C. 10:60-1.2, Definitions, has been expanded and clarified. Five new definitions are being added as follows: "Class C boarding home" means a boarding home which offers personal assistance as well as room and board, as defined by the Department of Community Affairs (see N.J.A.C. 5:27); "Division" means the Division of Medical Assistance and Health Services; "on-site monitoring" means a visit by Division staff to a homemaker agency, private duty nursing agency, or hospice agency to monitor compliance with Medicaid regulations cited in this manual; "physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices; and "primary caregiver" means an adult relative or significant other adult who accepts 24 hour responsibility for the health and welfare of the recipient. For the recipient to receive private duty nursing services in the Home and Community-Based Services waiver programs, the primary caregiver must reside with the recipient and provide a minimum of eight hours of hands-on care to the recipient in any 24 hour period.

2. Changes in the definitions of "homemaker/home health aide" and "personal care assistant" acknowledge the transfer of the certification process from the Department of Health to the Department of Law and Public Safety, Board of Nursing. The "Homemaker Agency" definition concerning accreditation conditions is being expanded to include the "Community Health Accreditation Program" (CHAP).

3. Clarification of the definition of "private duty nursing agency" to indicate that the agency shall be located/have an office in New Jersey, and shall have been in operation and actively engaged in home health care services in New Jersey for a period of not less than one year prior to application.

4. The substantive contents of N.J.A.C. 10:60-1.3 through 1.13 are being extracted from the existing N.J.A.C 10:60-2 and recodified. This recodification is accomplished by underlining the text, although it is not necessarily new material. Any new material is being explained in this Summary in the following paragraphs.

5. The addition of N.J.A.C. 10:60-1.6 is being proposed to reflect an existing reimbursement policy for out-of-State home health agencies.

6. Modifications of the limitations of private duty nursing services are being proposed in N.J.A.C. 10:60-1.9(c), regarding a live-in primary caregiver. These modifications allow for the administration of IV Therapy without this requirement. Additional modifications of private duty nursing services under Model Waiver III and ACCAP relate to the need of private duty nursing services being increased or decreased as the recipient's medical status changes, and correspondingly, as the service cost cap changes.

7. N.J.A.C. 10:60-1.9(f) has been revised to include the recent expansion of the weekly maximum for personal care assistant services to up to 40 hours per week and a listing of the criteria under which the additional hours per week may be provided.

8. N.J.A.C. 10:60-1.9(h) describes an existing policy that homemaker services under CCPED/HCEP shall be provided by certified homemaker-home health aides. In accordance with Federal regulations, homemaker services provided by a parent to a minor child or by a spouse to a spouse are not covered services and therefore are not reimbursable by the Division.

9. N.J.A.C. 10:60-1.10 adds Advance Directives provisions to the Manual in order to comply with the Federal Patient Self Determination Act (P.L. 101-508), 1902(w) of the Social Security Act, 42 U.S.C. 1396a.

10. Subchapter 2 is being recodified from what was previously subchapter 3. The old subchapter 3 citations and proposed new subchapter 2 citations with proposed amendments are being published as an integral part of this proposal. In addition, there are changes in the proposed new text of N.J.A.C. 10:60-2.2 which are described in the enumerated paragraphs.

11. N.J.A.C. 10:60-2.2(a)1 is being updated to reflect that recipients who are eligible under the New Jersey Care . . . Special Medicaid programs, including the Medically Needy segment are not covered or served under the CCPED Program.

12. N.J.A.C. 10:60-2.4(a) the generic term "the" is being replaced by the word "total" to clarify program costs at the beginning of the subsection.

13. In N.J.A.C. 10:60-2.5(a), fee payments to home health agencies participating in the CCPED program are being clarified by stipulating that the fees shall be based on the "lower" of audited cost report data (which is inflated to the current year), "Medicare cost limits or agency charges."

14. At N.J.A.C. 10:60-2.8(a)2 language is added to clarify aspects of recipient eligibility in the Model Waiver programs.

15. At N.J.A.C. 10:60-2.8(a)4, the Department proposes deletion of the paragraph, due to inappropriate terminology, in view of the clarification in paragraph (a)2.

16. N.J.A.C. 10:60-2.9(a) is amended to provide the chapter heading for N.J.A.C. 10:49, Administration.

17. N.J.A.C. 10:60-2.9(b)2 is revised and expanded concerning private duty nursing to include "payment by any source," and delineates when 24 hour emergency coverage may be authorized.

18. Proposed N.J.A.C. 10:60-2.9(b)2ii establishes those requirements for private duty nursing in emergency situations for cost of care provided through Model Waiver III which must be met as the service cost cap changes.

19. Proposed N.J.A.C. 10:60-2.9(b)2iii(2)(I) adds a requirement that evidence is maintained in a recipient's clinical record maintained at the agency and that the recipient was given information regarding advance directives.

20. At N.J.A.C. 10:60-2.10(a)1, existing language is clarified by adding the generic title "home health agencies" to costs associated with private duty nursing and personal care assistant services.

21. At N.J.A.C. 10:60-2.10(c), reference to Appendix F deleted and reference to the "Fiscal Agent Billing Supplement" is added.

22. At N.J.A.C. 10:60-2.10(d), the cross reference is changed to reflect recodification.

23. The amendments to N.J.A.C. 10:60-2.12(a) and (c) delete reference to AIDS Related Complex (ARC) terminology, as it is no longer an acceptable diagnosis and the change has been approved by the Federal Government.

24. The amendment to N.J.A.C. 10:60-2.14(a)3 clarifies the Medically Needy segment of the "New Jersey Care . . . Special Medicaid programs."

25. The proposed amendment to N.J.A.C. 10:60-2.15(a) contains general terminology update and expands "private duty nursing" services; clarifies requirements for specialized group foster care home for children services; details hospice services; and deletes obsolete language.

26. At N.J.A.C. 10:60-3.2(d), proposed terminology expands and specifies that language contained in State legislation, P.L. 1988, c.92, which indicates that if CCPED services are available, a person is not eligible for HCEP.

27. At N.J.A.C. 10:60-3.3(a)3 now includes a certification requirement for a home-health aide, as defined in N.J.A.C. 10:60-1.2.

28. The proposed N.J.A.C. 10:60-3.3(d) clarifies the current cost-sharing procedures for persons enrolled in the Home Care Expansion Program (HCEP).

29. The proposed N.J.A.C. 10:60-3.6(a)3 and 6 reinforce that a person determined financially eligible for Medicaid benefits shall be terminated from HCEP.

Additionally, this proposal deletes obsolete references, corrects spelling errors and generally updates nonsubstantive material.

Social Impact

The recodification of the Home Care Services Manual will have a positive impact on both providers and recipients. Subchapters in the Manual are better organized so that providers will more easily be able to understand program requirements. The revisions to the service requirements in the Manual will assure higher quality care to recipients.

For the most part, the revisions are familiar to both providers and recipients. The Manual revisions afford the opportunity to publicly an-

nounce them as a significant part of the programs. Service delivery will not be adversely impacted by the changes. Recipients are both Medicaid and State-only funded HCEP through Title XIX, or a waiver thereto, or State funded through HCEP. The intent of all home care programs is to enable persons to receive necessary care in the community, while avoiding the higher cost of institutionalization.

Economic Impact

There will be no economic impact on the government nor the public, because there is no change in reimbursement methodology or fees. Amendments have been made to N.J.A.C. 10:60-2.5(a) in order to provide cost information to case managers on an expedited basis, since audited cost report data provides retroactive, rather than prospective, information. The DMAHS has been utilizing this method, and, therefore, there is no actual change in practice. There will be no added costs to the delivery of services as the result of the reformatting of the Manual or the revisions as stated in the Summary. Home and Community-based Services Programs (CCPED, ACCAP and Model Waivers) are subject to Federal financial participation. The HCEP program is entirely State funded.

There is no cost to recipients or providers and no change in provider reimbursement.

Regulatory Flexibility Analysis

The proposed amendments will affect all Medicaid providers of home care services, some of which are small businesses, as defined in N.J.S.A. 52:14B-16 et seq.

The Department believes that the paramount interest is to protect the health, safety and welfare of Medicaid recipients; therefore, any small businesses among the home care providers should not be exempt from compliance with the rules. Thus, the requirements are equal for all providers' reporting and recordkeeping, regardless of size.

The addition of the provision regarding advance directives is Federal law and should not significantly affect provider costs.

Medicaid providers are required to keep sufficient records to indicate medical treatment provided to a recipient and any additional information as may be required (N.J.S.A. 30:4D-12(d)). The Division does not believe that home care services providers will incur any capital costs as a result of this proposal.

Medicaid providers are required to utilize sufficient professional staff, such as physicians, nurses, to insure compliance.

Full text of the proposed repeals can be found in the New Jersey Administrative Code at N.J.A.C. 10:60-2 and 6.

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

CHAPTER 60
HOME CARE SERVICES MANUAL

SUBCHAPTER 1. GENERAL PROVISIONS

10:60-1.1 [Scope] **Purpose and scope**

[(a) The Home Care Services Manual includes home health care services provided by a certified licensed home health agency and personal care assistant services provided by both a certified licensed home health agency and an accredited homemaker agency (proprietary and voluntary non-profit). The manual also describes the Medicaid Home and Community-based Services Programs and the State funded Home Care Expansion Program (HCEP).

(b) Home health agencies (certified licensed) shall provide nursing services and homemaker-home health aide services. Certain medical supplies shall be provided by the agency. Medical equipment and appliances shall be arranged for by the agency. Additional services may include physical therapy, occupational therapy, speech-language pathology services, medical social services, nutritional services, personal care assistant services, and other health care related services.

1. Medicaid reimbursement is available for these services when provided to Medicaid recipients (see 10:49-1 Administration Chapter, for definition of Medicaid recipient) in their places of residence, such as a private home, residential hotel, residential health care facility, rooming house and boarding home, but not in a hospital or nursing facility.

i. In residential health care facilities, homemaker-home health aide or personal care assistant services are excluded from Medicaid coverage.

2. Home health care services are provided or arranged by participating home health agencies based on the plan of care. All component services include instruction of the recipient, the family, and/or interested persons toward the recipient's ultimate degree of self-care and independence, supportive care and maintenance. Supplementation of home health care services may be necessary from a variety of other available community services in order to maintain the recipient in the home environment.

3. The provision of home health care services can range from a complex concentrated professional program (for acute care cases) which could require the services of a public health nurse, registered professional nurse, a licensed practical nurse, physical therapist, occupational therapist, speech-language pathologist, social worker, and homemaker-home health aide to a less complex program (as in chronic care cases) involving a homemaker-home health aide, personal care assistant and/or therapist and minimal visits by a registered nurse. The types of services provided, the frequency and the duration of these services are determined by the needs of each recipient. Only medically necessary home health services are reimbursed by the Division.

(c) Homemaker (proprietary and voluntary non-profit) agencies shall be approved to provide personal care assistant services, the initial nursing assessment visit and the personal care assistant nursing reassessment visit only, as outlined in 10:60-2.2.

(d) Medicaid District Office staff, periodically and on an on-going basis, shall perform case management and conduct post-payment quality assurance reviews to evaluate the appropriateness and quality of home health care services provided by a homemaker and a home health agency by telephone contacts and home visits to recipients and their caregivers. The findings from these quality assurance contacts shall be communicated to the provider and may result in an increase, reduction or termination of services.]

(a) The purpose of the home care services program, as delineated in this chapter, is to provide home care services to those individuals determined eligible.

(b) The Home Care Services Manual provides requirements for, and information about, the following programs:

1. Home health services;

2. Personal care assistant services;

3. Home and Community-Based Services Waiver programs, which include the following:

i. Home and Community-Based Services Waiver for the Elderly and Disabled, known as the Community Care Program for the Elderly and Disabled (CCPED);

ii. Home and Community-Based Services Waiver for Blind or Disabled Children and Adults (Model Waivers I, II, and III); and

iii. Home and Community-Based Services Waiver for Persons with AIDS and Children under five who are HIV Positive, known as AIDS Community Care Alternatives Program (ACCAP); and

4. Home Care Expansion Program (HCEP).

(c) Home health agencies, homemaker agencies, hospice agencies, and private duty nursing agencies are eligible to participate as Medicaid home care services providers. The services which each type of agency may provide and the qualifications required to participate as a Medicaid provider are listed in N.J.A.C. 10:60-1.2.

(d) General information about the home health services program and the personal care assistant services program are outlined in this subchapter. Specific program requirements are provided in N.J.A.C. 10:60-2.

(e) Requirements of the Home and Community-Based Services Waiver Programs and the Home Care Expansion Program are provided in N.J.A.C. 10:60-2 and 3, respectively.

(f) N.J.A.C. 10:60-4 HCFA Common Procedure Coding System—HCPCS, outlines the procedure codes used to submit a claim for services provided under the Personal Care Assistant services program, Home and Community-Based Services Waiver programs, and the Home Care Expansion Program.

10:60-1.2 Definitions

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

"Case Management" [means the process as conducted by the Medicaid District Office staff for Medicaid recipients other than those under the waiver program. Case Management] is defined as the process of on-going monitoring by the Medicaid District Office staff, of the delivery and quality of **home care** services, as well as the recipient/caregiver's satisfaction with the services. **Such case management does not include the case management services provided under the waiver programs and HCEP (N.J.A.C. 10:60-2.3(b)1, 2.9(b)1 and 3.3(a)1).** Case management ensures timely and appropriate provider responses to changes in care needs and

assures delivery of coordinated services which promote maximum restoration and prevents unnecessary deterioration.

"Class C boarding home" means a boarding home which offers personal assistance as well as room and board, as defined by the Department of Community Affairs (see N.J.A.C. 5:27).

...

"Division" means the Division of Medical Assistance and Health Services.

...

"Homemaker agency" means a proprietary or voluntary non-profit agency approved by the Department of Human Services, Division of Medical Assistance and Health Services to provide Personal Care Assistant Services, and homemaker services under the Community Care Program for the Elderly and Disabled (CCPED) and the Home Care Expansion Program (HCEP)[.]

[The following conditions shall be met:

1. The agency shall be] **, and** accredited, initially and on an ongoing basis, by the Commission on Accreditation for Home Care Inc., the National HomeCaring Council, a Division of the Foundation for Hospice and Homecare **or the Community Health Accreditation Program (CHAP).**

"Homemaker-home health aide" means a person who:

1. Successfully completes a training program in personal care **assistant** services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide. A copy of the certificate issued by the New Jersey Department of Law and Public Safety, Board of Nursing or other documentation acceptable to the Division is retained in the **agency's** personnel file.

2. Successfully completes a minimum of 12 hours in-service education per year offered by the agency; and

3. Is supervised by a registered professional nurse [of] **employed by** a Medicaid approved home health agency provider.

"Hospice agency" means a **public agency or private organization (or subdivision of such organization) that is** Medicare certified **for** hospice [approved by the Department of Human Services, Division of Medical Assistance and Health Services] **care in accordance with N.J.A.C. 10:53A, and has a valid provider agreement with the Division** to provide hospice services. [under the AIDS Community Care Alternatives Program. (N.J.A.C. 10:60-3.13)]

"Hospice service" means **a** service **package** provided by a Medicaid approved hospice agency to recipients enrolled in the AIDS Community Care Alternatives Program (ACCAP) who are certified by an attending physician as terminally ill, with a life expectancy of up to six months. [Services are available on a daily 24-hour basis as needed within an individualized plan of care.] **The service package supports a philosophy and method for caring for the terminally ill emphasizing supportive and palliative, rather than curative care, and includes services such as home care, bereavement counseling, and pain control. (For information regarding hospice services to regular Medicaid recipients under Title XIX, see Hospice Services Manual N.J.A.C. 10:53A).**

"Levels of care" means two levels of home health care services, acute and chronic, provided by a certified, licensed home health agency, as needed, to Medicaid recipients, upon request of the attending physician.

1. "Acute home health care" [is a] **means** concentrated and/or complex professional and non-professional services on a continuing basis where there is anticipated change in condition and services required. [Acute home health care services may be provided for periods up to two months]

2. "Chronic home health care" [is] **means** either a long or short-term uncomplicated, professional and non-professional [care] **services**, where there is no anticipated change in condition and services required. [Chronic home health care services may be provided for periods of up to six months].

...

"Medicaid District Office" (MDO) means one of the Division's [county-based] offices located throughout the State, which, for purposes of this manual, administers a home care quality assurance program through its case management staff via [a] post-payment review.

...

"On-site monitoring" means a visit by Division staff to a homemaker agency, private duty nursing agency, or hospice agency to monitor compliance with this Manual.

...

"Personal care assistant" means a person who:

1. Successfully completed a training program in personal care services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing, as a homemaker-home health aide. A copy of the certificate or other documentation issued by the New Jersey Department of Law and Public Safety, Board of Nursing is retained in the **agency's** personnel file.

2. Successfully completes a minimum of 12 hours in-service education per year offered by the agency; and

3. Is supervised by a registered professional nurse **employed by** a Medicaid approved homemaker/personal care assistant provider agency.

...

"Physician" means a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

...

"Preadmission screening (PAS)" means that process by which all eligible Medicaid recipients, and individuals who may become Medicaid eligible within [six months] **180 days** following admission to a Medicaid certified nursing facility, **and** who are seeking admission to a Medicaid certified nursing facility receive [permission] **a preadmission** screening by the Medicaid District Office **professional staff** to determine appropriate placement prior to admission to a nursing facility [as] pursuant to N.J.S.A. 30:4D-17.10 (P.L. 1988, c.97).

"Primary caregiver" means an adult relative or significant other adult who accepts 24 hour responsibility for the health and welfare of the recipient. For the recipient to receive private duty nursing services in the Home and Community-Based Services Waiver Programs, the primary caregiver must reside with the recipient and provide a minimum of 8 hours of hands-on care to the recipient in any 24 hour period.

"Prior authorization" means the process of approval by the MDO **for certain services** prior to the provision of these services. [In the context of the home care manual prior] **Prior** authorization **also** may be applied in **other service areas** in situations of **an agency's** continued non-compliance with program requirements. **In accordance with N.J.A.C. 10:60-1.4, if a patient is enrolled in the Garden State Health Plan or a private HMO, authorization for reimbursement is required by the GSHP physician case manager or private HMO prior to rendering any service.**

"Private duty nursing" means individual and continuous nursing care, as different from part-time or intermittent care, provided by licensed nurses in the home to recipients under Model Waiver III and the AIDS Community Care Alternatives Program, **as well as eligible Early Periodic Screening Diagnosis and Treatment (EPSDT) recipients.**

"Private duty nursing agency" means a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved **by the Division** to provide private duty nursing services under Model Waiver III, [and] the AIDS Community Care Alternatives Program (ACCAP) **and EPSDT**. The private duty nursing agency shall **be located/have an office in New Jersey and shall** have been in operation and actively engaged in home **health** care services in New Jersey for a period of not less than one year prior to application.

...

"Social worker" means a person who has a master's degree from a graduate school of social work accredited by the Council on Social Work Education, [and] has one year of post-masters social work experience in a health care setting **and is licensed to practice social work in the State of New Jersey.**

...

10:60-1.3 Providers eligible to participate

(a) A home care agency or organization, as described in (a)1 through 4 below, is eligible to participate as a New Jersey Medicaid provider of specified home care services in N.J.A.C. 10:49-3.2:

1. A home health agency, as defined in N.J.A.C. 10:60-1.2;

i. Out-of-State home health agencies providing services to Medicaid recipients out of State, must meet the requirements of that state, including licensure, if applicable, and must meet all applicable Federal requirements.

2. A homemaker agency, as defined in N.J.A.C. 10:60-1.2;

i. A new provider shall be issued a Medicaid Provider Billing Number by the fiscal agent. Those Personal Care Assistance (PCA) providers already enrolled as providers of homemaker services in the CCPED program (see N.J.A.C. 10:60-2) shall use the same Medicaid Provider Billing Number issued for CCPED.

3. A private duty nursing agency, as defined in N.J.A.C. 10:60-1.2; and

4. A hospice agency, as defined in N.J.A.C. 10:60-1.2.

10:60-1.4 Covered home health services

(a) Home health care services covered by the New Jersey Medicaid program are limited to those services provided directly by a home health agency approved certified for Medicaid by the New Jersey Department of Health and approved in accordance to participate in the New Jersey Medicaid program or through arrangement by that agency for other services.

1. Medicaid reimbursement is available for these services when provided to Medicaid recipients in their place of residence, such as a private home, residential hotel, residential health care facility, rooming house and boarding home.

i. In residential health care facilities, homemaker-home health aide or personal care assistant services are excluded from Medicaid coverage.

ii. Home health services shall not be available to Medicaid recipients in a hospital or nursing facility.

(b) Covered home health care services are those services provided according to medical, nursing and other health care related needs, as documented in the individual plan of care, on the basis of medical necessity and on the goals to be achieved and/or maintained.

(c) Home health care services shall be directed toward rehabilitation and/or restoration of the recipient to the optimal level of physical and/or mental functioning, self-care and independence, or directed toward maintaining the present level of functioning and preventing further deterioration, or directed toward providing supportive care in declining health situations.

(d) The types of home health agency services covered include professional nursing by a public health nurse, registered professional nurse, or licensed practical nurse; homemaker-home health aide services; physical therapy; speech-language pathology services; occupational therapy; medical social services; nutritional services; certain medical supplies; and personal care assistant services, as defined in this section.

1. The home health agency shall provide comprehensive nursing services under the direction of a public health nurse supervisor/director as defined by the New Jersey State Department of Health. These services shall include, but not be limited to, the following:

i. Participating in the development of the plan of care with other health care team members, which includes discharge planning;

ii. Identifying the nursing needs of the recipient through an initial assessment and periodic reassessment;

iii. Planning for management of the plan of care particularly as related to the coordination of other needed health care services;

iv. Skilled observing and monitoring of the recipient's responses to care and treatment;

v. Teaching, supervising and consulting with the recipient and family and/or interested persons involved with his or her care in methods of meeting the nursing care needs in the home and community setting;

vi. Providing direct nursing care services and procedures including, but not limited to:

(1) Wound care/decubitus care and management;

(2) Enterostomal care and management;

(3) Parenteral medication administration; and

(4) Indwelling catheter care.

vii. Implementing restorative nursing care measures involving all body systems including, but not limited to:

(1) Maintaining good body alignment with proper positioning of bedfast/chairfast recipients;

(2) Supervising and/or assisting with range of motion exercises;

(3) Developing the recipient's independence in all activities of daily living by teaching self-care, including ambulation within the limits of the treatment plan; and

(4) Evaluating nutritional needs including hydration and skin integrity; observing for obesity and malnutrition;

viii. Teaching and assisting the recipient with practice in the use of prosthetic and orthotic devices and durable medical equipment as ordered;

ix. Providing the recipient and the family or interested persons support in dealing with the mental, emotional, behavioral, and social aspects of illness in the home;

x. Preparing nursing documentation including nursing assessment, nursing history, clinical nursing records and nursing progress notes; and

xi. Supervising and teaching other nursing service personnel.

2. Homemaker-home health aide services shall be performed by a New Jersey certified homemaker-home health aide, under the direction and supervision of a registered professional nurse. Services include personal care, health related tasks and household duties. In all areas of service, the homemaker-home health aide shall encourage the well members of the family, if any, to carry their share of responsibility for the care of the recipient in accordance with the written established professional plan of care.

i. Household duties shall be considered covered services only when combined with personal care and other health services provided by the home health agency. Household duties may include such services as the care of the recipient's room, personal laundry, shopping, meal planning and preparation. In contrast, personal care services may include assisting the recipient with grooming, bathing, toileting, eating, dressing, and ambulation. The determining factor for the provision of household duties shall be based upon the degree of functional disability of the recipient, as well as the need for physician prescribed personal care and other health services, and not solely the recipient's medical diagnosis.

ii. The registered professional nurse, in accordance with the physician's plan of care, shall prepare written instructions for the homemaker-home health aide to include the amount and kind of supervision needed of the homemaker-home health aide, the specific needs of the recipient and the resources of the recipient, the family, and other interested persons. Supervision of the homemaker-home health aide in the home shall be provided by the registered professional nurse or appropriate professional staff member at a minimum of one visit every two weeks when in conjunction with skilled nursing, physical or occupational therapy or speech-language pathology services. In all other situations, supervision shall be provided at the frequency of one visit every 30 days. Supervision may be provided up to one visit every two months, if written justification is provided in the agency's records.

iii. The registered professional nurse, and other professional staff members, shall make visits to the recipient's residence to observe, supervise and assist, when the homemaker-home health aide is present or when the aide is absent, to assess relationships between the home health aide and the family and recipient and determine whether goals are being met.

3. Special therapies include physical therapy, speech-language pathology services and occupational therapy. Special therapists/pathologists shall review the initial plan of care and any change in the plan of care with the attending physician and the professional nursing staff of the home health agency. The attending physician shall be given an evaluation of the progress of therapies provided as well as the recipient's reaction to treatment and any change in the recipient's condition. The attending physician shall approve of any changes in the plan of care and delivery of therapy services.

i. The attending physician shall prescribe in writing the specific methods to be used by the therapist and the frequency of therapy

services. "Physical therapy as needed" or a similarly worded blanket order by the attending physician is not acceptable.

ii. Special therapists shall provide instruction to the home health agency staff, the recipient, the family and/or interested persons in follow-up supportive procedures to be carried out between the intermittent services of the therapists to produce the optimal and desired results.

(1) When the agency provides or arranges for physical therapy services, they shall be provided by a licensed physical therapist. The duties of the physical therapist shall include, but not be limited to, the following:

(A) Evaluating and identifying the recipient's physical therapy needs;

(B) Developing long and short-term goals to meet the individualized needs of the recipient and a treatment plan to meet these goals. Physical therapy orders shall be related to the active treatment program designed by the attending physician to assist the recipient to his or her maximum level of function which has been lost or reduced by reason of illness or injury;

(C) Observing and reporting to the attending physician the recipient's reaction to treatment, as well as, any changes in the recipient's condition;

(D) Documenting clinical progress notes reflecting restorative procedures needed by the recipient, care provided and the recipient's response to therapy along with the notification and approval received from the physician; and

(E) Physical therapy services which may include, but not be limited to, active and passive range of motion exercises, ambulation training, and training for the use of prosthetic and orthotic devices. Physical therapy does not include physical medicine procedures, administered directly by a physician or by a physical therapist which are purely palliative; for example, applications of heat in any form, massage, routine and/or group exercises, assistance in any activity or in the use of simple mechanical devices not requiring the special skill of a qualified physical therapist.

(2) When the agency provides or arranges for speech-language pathology services, the services shall be provided by a certified speech-language pathologist. The duties of a speech-language pathologist shall include, but not be limited to, the following:

(A) Evaluating, identifying, and correcting the individualized problems of the communication impaired recipient;

(B) Developing long and short-term goals and applying speech-language pathology service procedures to achieve identified goals;

(C) Coordinating activities with and providing assistance to a certified audiologist, when indicated;

(D) Observing and reporting to the attending physician the recipient's reaction to treatment, as well as, any changes in the recipient's condition; and

(E) Documenting clinical progress notes reflecting restorative procedures needed by the recipient, the care provided, and the recipient's response to therapy, along with the notification and approval received from the physician.

(3) The need for occupational therapy is not a qualifying criterion for initial entitlement to home health services benefits. However, if an individual has otherwise qualified for home health benefits, his or her eligibility for home health services may be continued solely because of his or her need for occupational therapy. Occupational therapy services shall include, but not be limited to, activities of daily living, use of adaptive equipment, and home-making task oriented therapeutic activities. When the agency provides or arranges for occupational therapy services, the services shall be provided by a registered occupational therapist. The duties of an occupational therapist shall include, but not be limited to, the following:

(A) Evaluating and identifying the recipient's occupational therapy needs;

(B) Developing long and short-term goals to meet the indivudalized needs of the recipient and a treatment plan to achieve these needs;

(C) Observing and reporting to the attending physician the recipient's reaction to treatment as well as any changes in the recipient's condition;

(D) Documenting clinical progress notes reflecting restorative procedures needed by the recipient, the care provided, and the recipient's response to therapy along with the notification and approval received from the physician; and

(E) Occupational therapy services shall include but not be limited to activities of daily living, use of adaptive equipment, and homemaking task oriented therapeutic activities.

4. When the agency provides or arranges for medical social services, the services shall be provided by a social worker, or by a social work assistant under the supervision of a social worker. These shall include, but not be limited to, the following:

i. Identifying the significant social and psychological factors related to the health problems of the recipient and reporting any changes to the home health agency;

ii. Participating in the development of the plan of care, including discharge planning, with other members of the home health agency;

iii. Counseling the recipient and family/interested persons in understanding and accepting the recipient's health care needs, especially the emotional implications of the illness;

iv. Coordinating the utilization of appropriate supportive community resources, including the provision of information and referral services; and

v. Preparing psychosocial histories and clinical notes.

5. When the agency provides or arranges for nutritional services, the services shall be provided by a registered dietitian or nutritionist. These services shall included, but are not limited to, the following:

i. Determining the priority of nutritional care needs and developing long and short-term goals to meet those needs;

ii. Evaluating the recipient's home situation, particularly the physical areas available for food storage and preparation;

iii. Evaluating the role of the family/interested persons in relation to the recipient's diet control requirements;

iv. Evaluating the recipient's nutritional needs as related to medical and socioeconomic status of the home and family resources;

v. Developing a dietary plan to meet the goals and implementing the plan of care;

vi. Instructing recipient, other home health agency personnel and family/interested persons in dietary and nutritional therapy; and

vii. Preparing clinical and dietary progress notes.

6. Medical supplies, other than drugs and biologicals, including, but not limited to, gauze, cotton bandages, surgical dressing, surgical gloves, ostomy supplies, and rubbing alcohol shall be normally supplied by the home health agency as needed to enable the agency to carry out the plan of care established by the attending physician and agency staff.

i. When a recipient requires more than one month of medical supplies, prior authorization for the supplies shall be requested and received from the appropriate Medicaid District Office. Requests for prior authorization of an unusual or an excessive amount of medical supplies provided by an approved medical supplier shall be accompanied by a personally signed, legible prescription from the attending physician. If a recipient is an enrollee of the Garden State Health Plan or a private HMO, prior authorization shall be obtained from the GSHP physician case manager or private HMO.

ii. When a recipient requires home parenteral therapy, the home health agency shall arrange the therapy prescribed with a medical supplier specialized to provide such services.

(1) Administration kits, supply kits and parenteral therapy pumps, not owned by the home health agency, shall be provided to the recipient and billed to the Medicaid program by the medical supplier.

(2) Provision of disposable parenteral therapy supplies which are required to properly administer prescribed therapy shall be the responsibility of the agency.

7. Personal care assistant services shall be as described in N.J.A.C. 10:60-1.7.

(e) Medical equipment is an item, article or apparatus which is used to serve a medical purpose, is not useful to a person in the absence of disease, illness or injury, and is capable of withstanding repeated use (durable). When durable medical equipment is essential in enabling the home health agency to carry out the plan of

care for a recipient, a request for authorization for the equipment shall be made by an approved medical supplier. The request for authorization shall be submitted to the Medicaid District Office and shall include a personally signed, legible prescription from the attending physician, as well as a personally signed legible prescription from the GSHP physician case manager (if not the prescriber) and private HMO, if applicable. Durable medical equipment, either rented or owned by the home health agency, shall not be billed to the New Jersey Medicaid program (see Medical Supplier Services Manual, N.J.A.C. 10:59-1.5 and 1.7).

10:60-1.5 Certification of need for services

To qualify for payment of home health services by the New Jersey Medicaid program, the recipient's need for services shall be certified in writing to the home health agency by the attending physician. The nurse or therapist shall immediately record and sign verbal orders and obtain the physician's counter signature, in conformance with written agency policy.

10:60-1.6 Plan of care

(a) The plan of care shall be developed by the attending physician in cooperation with agency personnel. It shall include, but not be limited to, medical, nursing, and social care information. The plan shall be re-evaluated by the nursing staff at least every two months and revised as necessary, appropriate to the recipient's condition. The following shall be part of the plan of care:

1. The recipient's major and minor impairments and diagnoses;
2. A summary of case history, including medical, nursing, and social data;
3. The period covered by the plan;
4. The number and nature of service visits to be provided by the home health agency;
5. Additional health related services supplied by other providers;
6. A copy of physician's orders and their updates;
7. Medications, treatments and personnel involved;
8. Equipment and supplies required;
9. Goals, long and short-term;
10. Preventive, restorative, maintenance techniques to be provided, including the amount, frequency and duration;
11. The recipient's, family's, and interested persons involvement (for example, teaching); and
12. Discharge planning in all areas of care (coordinated with short and long-term goals);

i. As a significant part of the plan of care, a recipient's potential for improvement shall be periodically reviewed and appropriately revised. These revisions shall reflect changes in the medical, nursing, social and emotional needs of the recipient, with attention to the economic factors when considering alternative methods of meeting these needs.

ii. Discharge planning shall take the recipient's preferences into account when changing the intensity of care in his or her residence, arranging services with other community agencies, and transferring to or from home health providers. Discharge planning also provides for the transfer of appropriate information about the recipient by the referring home health agency to the new providers to ensure continuity of health care.

(b) The plan of care shall include the recipient's needs, make a nursing diagnosis, develop a nursing plan of care, provide nursing services and coordinate other therapeutic services to implement the approved medical and nursing plan of care.

(c) The plan of care shall include an assessment of the recipient's acceptance of his or her illness and recipient's receptivity to home health care services.

(d) The plan of care shall include a determination of the recipient's psycho-social needs in relation to the utilization of other community resources.

(e) The plan of care shall include a description of social services, when provided by the social worker, and be reviewed, with any referrals required to meet the needs of the recipient.

10:60-1.7 Clinical records

(a) Clinical records containing pertinent past and current information, recorded according to accepted professional standards, shall be maintained by the home health agency for each recipient receiving home health care services. The clinical record shall include, at a minimum, the following:

1. A plan of care as described in N.J.A.C. 10:60-1.6;
2. Appropriate identifying information;
3. The name, address and telephone number of recipient's physician;
4. Clinical notes by nurses, social workers, and special therapists, which shall be written, signed and dated on the day each service is provided;
5. Clinical notes to evaluate a recipient's response to service on a regular, periodic basis, which shall be written, signed and dated by each discipline providing services;
6. Summary reports of pertinent factors from the clinical notes of the nurses, social workers, and special therapists providing services, which shall be submitted to the attending physician at least every two months; and
7. When applicable, transfer of the recipient to alternative health care, which shall include transfer of appropriate information from the recipient's record.

10:60-1.8 Basis of payment for home health services

(a) For home health services, the New Jersey Medicaid program follows the Medicare principles of reimbursement, which are based upon the lowest of:

1. 100 percent of reasonable covered costs; or
2. The published cost limits; or
3. Covered charges.

(b) Interim reimbursement shall be made on the basis of 100 percent or less (if reasonable allowable cost is anticipated to be less) of covered charges.

(c) Retroactive settlement and final reimbursement shall be based on Medicare principles of reimbursement.

10:60-1.9 Out-of-State approved home health agencies

(a) Final reimbursement shall be made to out-of-State approved home health agencies on the basis of 80 percent of covered reasonable charges. There is no cost filing required. No retroactive settlement shall be made.

10:60-1.10 Personal care assistant services

(a) Personal care assistant services shall be provided by a certified licensed home health agency or by a proprietary or voluntary non-profit accredited homemaker agency.

(b) Personal care assistant services are health related tasks performed by a qualified individual in a recipient's place of residence, under the supervision of a registered professional nurse, as certified by a physician in accordance with a written plan of care. These services are available from a home health agency or a homemaker agency.

1. The purpose of personal care is to accommodate long-term chronic or maintenance health care, as opposed to short-term skilled care required for some acute illnesses.
2. Personal care assistant services shall be reimbursable when provided to Medicaid recipients in their place of residence, including:

i. A private home;
ii. A rooming house;
iii. A boarding home (not Class C);
iv. A Division of Youth and Family Services' (DYFS) foster care home; or
v. A Division of Developmental Disabilities (DDD) foster care home.

(c) Personal care assistant services are described as follows:

1. Activities of daily living shall be performed by a personal care assistant, and include, but not be limited to:

i. Care of the teeth and mouth;
ii. Grooming such as, care of hair, including shampooing, shaving, and the ordinary care of nails;
iii. Bathing in bed, in the tub or shower;
iv. Using the toilet or bed pan;
v. Changing bed linens with the recipient in bed;
vi. Ambulation indoors and outdoors, when appropriate;

vii. Helping the recipient in moving from bed to chair or wheelchair, in and out of tub or shower;

viii. Eating and preparing meals, including special therapeutic diets for the recipient;

ix. Dressing;

x. Relearning household skills; and

xi. Accompanying the recipient to clinics, physician office visits, and/or other trips made for the purpose of obtaining medical diagnosis or treatment or to otherwise serve a therapeutic purpose.

2. Household duties that are essential to the recipient's health and comfort, performed by a personal care assistant shall include, but not be limited to:

i. Care of the recipient's room and areas used by the recipient, including sweeping, vacuuming, dusting;

ii. Care of kitchen, including maintaining general cleanliness of refrigerator, stove, sink and floor, dishwashing;

iii. Care of bathroom, including maintaining cleanliness of toilet, tub, shower and floor;

iv. Care of recipient's personal laundry and bed linen, which may include necessary ironing and mending;

v. Necessary bed-making and changing of bed linen;

vi. Re-arranging of furniture to enable the recipient to move about more easily in his or her room;

vii. Listing food and household supplies needed for the health and maintenance of the recipient;

viii. Shopping for above supplies, conveniently storing and arranging supplies, and doing other essential errands; and

ix. Planning, preparing and serving meals.

3. Health related activities, performed by a personal care assistant, shall be limited to:

i. Helping and monitoring recipient with prescribed exercises which the recipient and the personal care assistant have been taught by appropriate personnel;

ii. Rubbing the recipient's back if not contraindicated by physician;

iii. Assisting with medications that can be self-administered;

iv. Assisting the recipient with use of special equipment, such as walker, braces, crutches, wheelchair, after thorough demonstration by a registered professional nurse or physical therapist, with return demonstration until registered professional nurse or physical therapist is satisfied that recipient can use equipment safely;

v. Assisting the recipient with simple procedures as an extension of physical or occupational therapy, or speech-language pathology services; and

vi. Taking oral and rectal temperature, radial pulse and respiration.

(d) The duties of the registered professional nurse in the PCA program are as follows:

1. The registered professional nurse, in accordance with the physician's certification of need for care, shall perform an assessment and prepare a plan of care for the personal care assistant to implement. The assessment and plan of care shall be completed at the start of service. However, in no case shall the nursing assessment and plan of care be done more than 48 hours after the start of service. The plan of care shall include the tasks assigned to meet the specific needs of the recipient, hours of service needed, and shall take into consideration the recipient's strengths, the needs of the family and other interested persons. The plan of care shall be dated and signed by the personal care assistant and the registered nurse and shall include short-term and long-term nursing goals. The personal care assistant shall review the plan, in conjunction with the registered professional nurse.

2. Direct supervision of the personal care assistant shall be provided by a registered nurse at a minimum of one visit every 60 days, initiated within 48 hours of the start of service, at the recipient's place of residence during the personal care assistant's assigned time. The purpose of the supervision is to evaluate the personal care assistant's performance and to determine that the plan of care has been properly implemented. At this time, appropriate revisions to the plan of care shall be made. Additional supervisory visits shall be made as the situation warrants, such as a new PCA or in response to the physical or other needs of the recipient.

3. A personal care assistant nursing reassessment visit shall be provided at least once every six months, or more frequently if the recipient's condition warrants, to reevaluate the recipient's need for continued care.

(e) Recordkeeping for personal care assistant services shall include the following;

1. Clinical records and reports shall be maintained for each recipient, covering the medical, nursing, social and health related care in accordance with accepted professional standards. Such information must be readily available, as required, to representatives of the Division or its agents.

2. Clinical records shall contain, at a minimum,

i. An initial nursing assessment;

ii. A six-month nursing reassessment;

iii. A recipient-specific plan of care;

iv. Signed and dated progress notes describing the recipient's condition;

v. Documentation of the supervision provided to the personal care assistant every 60 days;

vi. A personal care assistant assignment sheet signed and dated weekly by the personal care assistant;

vii. Documentation that the recipient has been informed of rights to make decisions concerning his or her medical care; and

viii. Documentation of the formulation of an advance directive.

3. All clinical records shall be signed and dated by the registered professional nurse, in accordance with accepted professional standards, and shall include documentation described in 2 above.

10:60-1.11 Basis of payment for personal care assistant services

(a) Personal care assistant services shall be reimbursed on a per hour, fee-for-service basis for weekday, weekend and holiday services. Nursing assessment and reassessment visits under this program shall be reimbursed on a per visit, fee-for-service basis.

(b) Personal care assistant services reimbursement rates (see N.J.A.C. 10:60-4) are all inclusive maximum allowable rates. No direct or indirect cost over and above the established rates may be considered for reimbursement. At all times the provider shall reflect its standard charge on the Health Insurance Claim Form, 1500 N.J. (see Fiscal Agent Billing Supplement, Appendix A, incorporated herein by reference) even though the actual payment may be different. A provider shall not charge the New Jersey Medicaid program in excess of current charges to other payers.

(c) For reimbursement purposes only, a weekend means a Saturday or Sunday; a holiday means an observed agency holiday which is also recognized as a Federal or State holiday.

10:60-1.12 Limitations of home care services

(a) When the cost of home care services is equal to or in excess of the cost of institutional care over a protracted period (that is, six months or more), the MDO staff may opt to limit or deny the provision of home care services on a prospective basis.

(b) Private duty nursing shall be a covered service only for those recipients covered under EPSDT, Model Waiver III and the AIDS Community Care Alternatives Program (ACCAP). Under Model Waiver III and ACCAP, when payment for private duty nursing services is being provided by another source (that is, insurance), the Division will supplement payment up to a maximum of 16 hours per day, including services provided by the other sources, if medically necessary, and if cost of service provided by the Division is less than institutional care.

(c) Private duty nursing services shall be limited to a maximum of 16 hours in a 24 hour period, per person in Model Waiver III and ACCAP. There must be a live-in primary adult caregiver (as defined in N.J.A.C. 10:60-1.2) who accepts 24 hour per day responsibility for the health and welfare of the recipient unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60-2.9(b)2 for exceptions to 16 hour maximum in a 24 hour period.)

(d) For personal care assistant services, Medicaid reimbursement shall not be made for services provided to Medicaid recipients in the following settings:

1. A residential health care facility;
2. A Class C boarding home;
3. A hospital; or
4. A nursing facility.

(e) Personal care assistant services provided by a family member shall not be considered covered services and shall not be reimbursed by the New Jersey Medicaid program.

(f) Personal care assistant services shall be limited to a maximum of 25 hours per week. However, if there is a medical need for additional hours of service, this limit may be exceeded by the provider up to an additional 15 hours per week, under certain criteria, which follow:

1. If the caregiver is employed, ill, frail, or temporarily absent from the home for sickness or family emergency and therefore unable to participate adequately in providing medically necessary care to ensure the safety or well-being of the recipient;
2. If the recipient lives alone or has no caregiver, and is in need of medically necessary care to ensure his/her safety and well-being;
3. If the recipient is severely functionally limited and requires care to meet activities in daily living (ADL) needs, both in the morning and afternoon/evening; or
4. If the recipient's physical status/medical condition suddenly deteriorates, resulting in an increased need for personal care on a short-term basis until the stabilization of the health status.

(g) Additional hours under (f) above shall be medically indicated, as documented by the recipient's physician, and shall not be a companion service. The agency providing these increased services must notify the Medicaid District Office (MDO), either in writing or by telephone, about the recipient receiving more than 25 hours of PCA services. Failure to notify the MDO may result in non-payment of the hours in excess of the 25 hours. Services provided to these recipients will be included by the MDO in the post-payment quality assurance reviews.

(h) Homemaker services provided under CCPED/HCEP shall be provided by certified homemaker-home health aides. Homemaker services provided by a parent to a minor child or by a spouse to a spouse shall not be covered services and shall not be reimbursed by the Division.

10:60-1.13 Advance directives

(a) All home health, private duty nursing, hospice and personal care agencies participating in the New Jersey Medicaid program shall comply with the provisions of the Federal Patient Self Determination Act (P.L. 101-508) 1902(w) of the Social Security Act, 42 U.S.C. 1396a, and shall notify Medicaid recipients about their rights under P.L. 1991, c.201 to make decisions concerning their medical care and their right to formulate an advance directive.

1. Such agencies shall:

i. Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the home health or personal care agency about their rights under State law to make decisions concerning their medical care and the right to formulate an advance directive;

ii. Provide the New Jersey Department of Health (DOH) statement of New Jersey law, "Your Right to Make Health Care Decisions in New Jersey", to recipients upon initial visit for home health or personal care services, regarding their rights to make decisions concerning their medical care available from the DOH. Such rights include the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive for their health care;

iii. Provide written information to recipients, upon initial receipt of home health or personal care, concerning the agency's written policies on the implementation of such rights;

iv. Document in the recipient's medical record whether or not the recipient has executed an advance directive;

v. Not condition the provision of care, or otherwise discriminate against a recipient, based on whether or not the recipient has executed an advance directive;

vi. Ensure compliance with requirements of State law respecting advance directives; and

vii. Provide education for staff and the community on issues concerning advance directives.

2. The provisions in (a)1 above shall not prohibit the application of a State law which allows a home health or personal care agency to refuse to implement an advance directive based on conscientious objection. The New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201, does allow private religious affiliated health care institutions to develop institutional policies and practices defining circumstances in which they will decline to participate in the withholding or withdrawing of specific measures to sustain life. Such policies and practices shall be included in the health care agency's written policies.

10:60-1.14 Relationship of the home care provider with the Medicaid District Office (MDO)

(a) Preadmission screening (PAS) shall be required for all Medicaid-eligible individuals and other individuals applying for nursing facility (NF) services and/or the Home and Community-Based Services Waiver programs. MDO professional staff shall conduct PAS assessments of individuals in hospitals and community settings to evaluate need for nursing facility services and to determine the appropriate setting for the delivery of services. Individuals in hospitals or community settings who are referred for nursing facility care and who have been determined by the MDO not to require nursing facility placement, or who select alternatives to nursing facility care, will be referred for home care services.

(b) A health services delivery plan (HSDP) shall be completed by the MDO staff at the conclusion of the PAS assessment and shall be a component of the referral package to the home care provider. The HSDP shall be forwarded to the authorized care setting and shall be attached to the recipient's medical record upon admission to a nursing facility or when the recipient receives services from home care agencies. The HSDP may be updated as required to reflect changes in the recipient's condition. The HSDP provides data base history which reflects current or potential health problems and required services. The discharge planning unit or social service department of the hospital shall provide home care agencies with HSDPs for individuals who have been assessed in a hospital setting. The MDOs shall provide HSDPs for individuals who have been assessed in a community setting during the PAS process.

(c) For the many individuals in the community setting referred for home care services outside the PAS process described in (a) above, an HSDP shall not be provided.

10:60-1.15 Standards of performance for post payment quality assurance review

(a) An initial visit to evaluate the need for home health services or personal care assistant services shall be made by the provider. Following the initial visit, the provider shall advise the MDO, using the HCFA 485 form or other MDO approved notification form, that services have begun for the recipient.

1. If the HCFA 485 is used, it shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services, however, shall be kept on file in the agency, with the prescription. Providers shall include the HSP (Medicaid) Case Number when completing the form. For the non-Medicare certified agency, the provider shall submit to the MDO an MDO approved notification form which shall be signed by the agency nurse and need not be countersigned by the physician. The signature of the physician prescribing the services shall be kept on file in the agency.

2. The HCFA 485, or other appropriate MDO approved agency form, shall be submitted to the MDO upon initiation of services and once every 12 months thereafter on a continuing basis. Providers shall notify the MDO when services have been terminated.

3. On a random selection basis, MDO staff shall conduct post-payment quality assurance reviews. At the specific request of the MDO, the provider shall submit a plan of care and other documentation for those Medicaid recipients selected for a quality assurance review.

4. Upon completing the post-payment quality assurance review, the MDO shall forward a performance report to the provider, based on compliance with the standards described in this section.

(b) The professional staff from the MDO will use the standards listed below in (c) through (j) below to conduct a post-payment quality assurance review of home care services as provided to the Medicaid recipient.

(c) Skilled nursing services and visits shall be based on a comprehensive assessment performed by a registered professional nurse to identify care needs and required services and shall be provided as designated by the plan of care.

1. Home visits for nursing services shall be provided to the recipient as ordered by the physician and as designated by the standards of nursing practice.

2. The nurse shall make home visits as appropriate and as scheduled in the plan of care. Supervision of home health aide services is an integral component of these visits.

3. Services shall be within the scope of practice of personnel assigned.

4. Appropriate referrals for required services shall be instituted on a timely basis.

5. Nursing progress notes and plans of care shall reflect the significant changes in condition which require changes in the scope and timeliness of service delivery.

(d) Homemaker-home health aide and personal care assistant services shall be provided by the agency in accordance with the plan of care.

1. The aide shall arrive and leave each day as scheduled by the agency.

2. The same aide shall be assigned on a regular basis, with the intent of assuring continuity of care for the recipient, unless there are unsusual documented circumstances, such as a difficult recipient/caregiver relationship, difficult location, or personal reasons of aide or recipient/caregiver.

3. Services shall be within the scope of practice of personnel assigned.

4. Appropriate training and orientation shall be provide by licensed personnel to assure the delivery of required services.

5. The aide shall provide appropriate services as reflected in the plan of care and identified on the assignment sheet;

6. Home care services shall be provided to the recipient to maintain the recipient's health or to facilitate treatment of an illness or injury.

(e) Physical therapy, occupational therapy or speech-language pathology services shall be provided as an integral part of a comprehensive medical program. Such rehabilitative services shall be provided through home visits for the purpose of attaining maximum reduction of physical or mental disability and restoration of the individual to the best functional level.

1. The services shall be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the individual shall improve materially in a reasonable and generally predictable period of time, or that the services are necessary towards the establishment of a safe and effective maintenance program.

2. The complexity of rehabilitative services is such that it can only be performed safely and effectively by a therapist. The services shall be consistent with the nature and severity of the illness or injury. The amount and frequency of these services shall be reasonable and necessary, and the duration of each visit shall be a minimum of 30 minutes.

3. The services shall be specific and effective treatment for the recipient's condition and shall be provided in accordance with accepted standards of medical practice.

4. For physical therapy standards, see N.J.A.C. 10:60-1.4(d)3ii(l).

(f) Visits of social service professionals are necessary to resolve social or emotional problems that are, or may be, an impediment to the effective treatment of the individual's medical condition or rate of recovery.

1. Medical social services shall be provided as ordered by the physician and furnished by the social worker.

2. The plan of care shall indicate the appropriate action taken to obtain the available community resources to assist in resolving the recipient's problems or to provide counseling services which are reasonable and necessary to treat the underlying social or emotional problems which are impeding the recipient's recovery.

3. The services shall be responsive to the problem and the frequency of the services shall be for a prescribed length of time.

(g) Visits of a dietitian or nutritionist shall be provided as needed to resolve nutritional problems which are or may be an impediment to the effective treatment of the recipient's medical condition or rate of recovery.

1. Nutritional services shall be provided as ordered by the physician and furnished by a dietitian or nutritionist in accordance with accepted standards of professional practice.

2. The plan of care shall indicate the nutritional care needs and the goals to meet those needs.

3. Services shall be provided to the recipient and/or the family/interested others involved with the recipient's nutritional care.

4. The services shall be specific and for a prescribed period of time.

5. The progress notes and care plan shall reflect significant changes or problems which require changes in the scope and timeliness of service delivery visits.

(h) The services shall be provided to the satisfaction of the recipient/caregiver.

1. There shall be documented evidence that the recipient/caregiver has participated in the development of the plan of care.

2. Identified problems shall be resolved between the agency and the recipient/caregiver, when possible.

3. The agency shall make appropriate referrals for unmet recipient needs.

4. The recipient/caregiver shall be promptly informed of changes in aides and/or schedules.

5. Recipients/caregivers shall be aware of the agency name, telephone number, and contact person in the event of a problem.

(i) The home health agency shall be aware of the recipient's need for, and shall make the appropriate arrangements for, securing medical equipment, appliances and supplies, as follows:

1. The agency shall assist the recipient in obtaining equipment, appliances, and supplies when needed under Medicare and/or Medicaid guidelines;

2. The agency shall monitor equipment, appliances and supplies to assure that all items are serviceable and used safely and effectively; and

3. The agency shall be responsible for contacting the provider for problems relating to the utilization of equipment, appliances and supplies.

(j) Recordkeeping shall be timely, accurate, complete and legible, in accordance with this chapter, and as follows:

1. There shall be a current aide assignment sheet for each recipient, available either in the home or at the agency, dated and signed by the nurse. The assignment shall be based on a nursing assessment of the recipient's needs and shall list the aide's duties as required in the plan or care;

2. The agency shall document significant changes in health and/or social status, including recent hospitalization, in the progress notes and make appropriate changes in the plan of care as needed;

3. Initial evaluations and progress notes shall be provided to the MDO upon request for all nursing services; and

4. Initial evaluations, progress notes and goals shall be provided to the MDO upon request for physical, occupational and speech-language therapies and social services.

10:60-1.16 On-site monitoring visits

(a) For a homemaker agency and a private duty nursing agency, on-site monitoring visits shall be made periodically by Division staff to the agency to review compliance with personnel, recordkeeping and service delivery requirements (Home Care Agency Review Form, FD-342). The results of such monitoring visits shall be reported to the agency, by the Medicaid District Office, and when indicated, a plan of correction shall be required. Continued non-compliance with requirement shall result in such sanctions as curtailment of accepting new recipients for services, suspension or rescission of the agency's provider agreement.

(b) For a hospice agency, on-site monitoring visits shall be made periodically by Division staff to the agency to review compliance with personnel, recordkeeping and service delivery requirements (Hospice Agency Review Summary Form, FD-351). The results of such monitoring visits shall be reported to the agency with a copy to the Medicaid District Office, and when indicated, a plan of correction shall be required. Continued non-compliance with requirements shall result in such sanctions as curtailment of accepting new recipients for services, suspension or rescission of the agency's provider contract.

10:60-1.17 Provisions for fair hearings

Providers and recipients can request fair hearings as set forth in the Administration chapter at N.J.A.C. 10:49-9.10.

SUBCHAPTER [3.]**2.** HOME AND COMMUNITY-BASED [SERVICE] **SERVICES WAIVER PROGRAMS**

10:60-[3.1]**2.1** (No change in text.)

10:60-[3.2]**2.2** Eligibility requirements for CCPED

(a) Financial eligibility for CCPED is determined by the county welfare agency/board of social services which serves the county where an individual resides. The standards used for income eligibility are set forth in N.J.A.C. 10:71-5.6(c)4, Table B, entitled "Variations in Living Arrangements." Both the Supplemental Security Income (SSI) community standard and the Medicaid institutional standard appear in this table. The actual amounts, recomputed periodically based upon the cost-of-living increase, are subject to change each time a cost-of-living increase occurs.

1. Recipients financially eligible for Medicaid services under the community eligibility standards are not covered under CCPED. CCPED also does not serve recipients who are eligible under **the New Jersey Care ... Special Medicaid Programs, including** the Medically Needy **segment of that** program, **or enrolled in the Garden State Health Plan or private HMO serving the Medicaid eligible population.**

(b)-(e) (No change.)

10:60-[3.3]**2.3** (No change in text.)

10:60-[3.4]**2.4** Procedures used as financial controls for CCPED

(a) [The] **Total** program costs shall be restricted by limits placed on the number of community care slots assigned each county and on per recipient costs. The Division may elect to exclude individuals for whom there is an expectation that costs to Medicaid for waiver services may exceed the cost of nursing facility care.

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

10:60-[3.5]**2.5** Basis for home health agency reimbursement and cost reporting (CCPED)

(a) A home health agency participating in the CCPED **program** shall be reimbursed by the New Jersey Medicaid program on a fee-for-service basis for home health services provided. Fees shall be based on **the lower of** audited cost report data which is inflated to the current year, **Medicare cost limits or agency charges.** Agencies shall be precluded from receiving additional reimbursement for the cost of the community care services above the fee established by the Medicaid program. This applies to both freestanding and hospital-based home health agencies.

1. (No change.)

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

Recodify existing N.J.A.C. 10:60-3.6 and 3.7 as **2.6 and 2.7** (No change in text.)

10:60-2.8 Eligibility requirements for Model Waivers

(a) Program eligibility criteria for Model Waivers are as follows:

1. (No change.)

2. [For all Model Waivers, a recipient's total income shall exceed the SSI community standard up to the institutional cap or be ineligible in the community because of SSI deeming rules. Model Waiver III, however, may also serve recipients who are eligible for Medicaid in the community.] **For Model Waiver I and II, a recipient's total income shall exceed the SSI community standard, up to the institutional cap or the recipient must be ineligible in the community because of SSI deeming rules. Model Waiver III, however, shall serve the recipient who is eligible for Medicaid in the community, including New Jersey Care ... Special Medicaid Programs, as well as the recipient whose total income exceeds the community standard, up to the institutional cap. Model Waiver III shall not serve a Medicaid recipient eligible under the Medically Needy segment of the New Jersey Care ... Special Medicaid Programs nor enrolled in the Garden State Health Plan or a private Health Maintenance Organization (HMO) serving the Medicaid eligible population.**

3. (No change.)

[4. Recipients who are financially Medicaid eligible under the community eligibility standards are not eligible for Model Waiver I and II. Model Waiver III, however, may serve these recipients, except for those recipients served under the Medically Needy Program.]

Recodify existing 5-7 as **4 through 6.** (No change in text.)

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

10:60-[3.9]**2.9** Services included under the Model Waiver programs

(a) Except for nursing facility services, all approved services under the New Jersey Medicaid program as described in N.J.A.C. 10:49, **Administration**, are available under the Model Waiver programs from approved Medicaid providers.

(b) Additional waivered services are as follows:

1. (No change.)

2. Private-duty nursing: A waivered service provided under Model Waiver III only and not under Model Waiver I or II. Private-duty nursing shall be provided in the community only, not in an inpatient hospital setting. The recipient shall have a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the recipient. A maximum of 16 hours of private-duty nursing **includes payment by any source** may be provided in any 24-hour period. **Provision of the additional eight hours of care shall be the responsibility of the primary caregiver. There is no 24 hour coverage except for a limited period of time under the following emergency circumstances and when prior authorized by the Office of Home Care Programs:**

i. For brief post-hospital periods while the caregiver(s) adjust(s) to the new responsibilities of caring for the discharged recipient; or

ii. In emergency situations such as the illness of the caregiver when private duty nursing is currently being provided. In these situations, more than 16 hours of private duty nursing services may be provided for a limited period until other arrangements are made for the safety and care of the recipient.

(c) The need for private duty nursing services is established initially by the RSN upon completion of the PAS-1 and HSDP (N.J.A.C. 10:60-1.11(a)). The number of hours of private duty nursing included in the service plan is based upon the recipient's medical need and the cost of service. The total cost of all services provided through Model Waiver III must be less than the cost of care in an appropriate institution. The need for private duty nursing services and the hours of private duty nursing services may increase or decrease as the recipient's medical status changes, and correspondingly, as the service cost cap changes.

[i.](**1**) (No change in text.)

[ii.](**2**) Clinical records maintained at the agency shall contain at a minimum the following:

Recodify existing (1) through (6) as (**A**) **through** (**F**) (No change in text.)

[(7)](**G**) A nursing care plan; [and]

[(8)](**H**) Signed and dated progress notes describing recipient's condition[.]; **and**

(I) Evidence that recipient was given information regarding advance directives.

Recodify existing iii through vi as (**3**) **through** (**6**) (No change in text.)

(c) (No change.)

10:60-[3.10]**2.10** Basis for reimbursement for Model Waiver services

(a) A [home health agency] provider of private-duty nursing services and personal care assistant services shall be reimbursed by the New Jersey Medicaid program on a fee-for-service basis for services provided. Providers shall be precluded from receiving additional reimbursement for the cost of these services above the fee established by the Medicaid program.

1. All costs associated with the provision of private-duty nursing and personal care assistant services **by home health agencies** shall be included in the routine Medicare/Medicaid cost-reporting mechanism.

(b) (No change.)

(c) Home health services are billed on the UB-82 HCFA-1450 form [(Appendix F, incorporated herein by reference)] **(see Fiscal Agent Billing Supplement).**

(d) See N.J.A.C. 10:60-[5]**4** for codes to be used when submitting claims for waiver services for Model Waiver Program, I, II or III.

10:60-[3.12]**2.12** AIDS Community Care Alternatives Program (ACCAP)

(a) The AIDS Community Care Alternatives Program (ACCAP) is a renewable Federal waiver program which offers home and community-based services to recipients with Acquired Immune Deficiency Syndrome (AIDS) [or with AIDS Related Complex (ARC)] and children up to the age of five who are HIV positive.

(b) (No change.)

(c) The program is Statewide with slots allocated to each county based upon the estimated number of AIDS[/ARC] recipients to be served.

(d) (No change.)

10:60-[3.14]**2.14** Eligibility criteria

(a) Recipients eligible for ACCAP shall be:

1. Diagnosed as having AIDS [or ARC], or be a child up to the age of five who is HIV positive.

2. (No change.)

3. Categorically needy, that is, recipients who are Medicaid eligible in the community, except for those served under the Medically Needy **segment of the New Jersey Care ... Special Medicaid** Programs; or **enrolled in the GSHP or private HMO serving the Medicaid eligible population.**

4. (No change.)

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

10:60-[3.15]**2.15** ACCAP services

(a) All Medicaid services, except for nursing facility services, are available under ACCAP in accord with an individualized plan of care. Additionally, the following services are available to the eligible recipient:

1. Case management: A process in which a public health nurse or social worker (MSW) in a community agency is responsible for planning, locating, coordinating and monitoring a group of services designed to meet the individual needs of the recipient being served.

i. [Case Management] **Special Child Health** Units under contract to the New Jersey State Department of Health shall provide case management services to children up to the age of 21.

ii.-iii. (No change.)

2. Private-duty nursing (PDN): Care provided by a registered professional nurse or licensed practical urse. PDN is continuous rather than part-time or intermittent, **provided in the community only, not in an inpatient hospital setting.** A nurse shall be employed by a licensed home health agency, voluntary non-profit homemaker/home health aide agency, private employment agency and temporary-help service agency approved by Medicaid to provide PDN services. PDN services shall be provided up to 16 hours per day, per person, but ony when there is a live-in primary adult caregiver who accepts 24-hour per day responsibility for the health and welfare of the individual (see N.J.A.C. 10:60-[3.9(b)2] **2.9(b)2** for recordkeeping requirements) **unless the sole purpose of the private duty nursing is the administration of IV therapy. The maximum of 16 hours includes payment by any source in any 24 hour period.**

i. The need for private duty nursing services is established initially by the RSN upon completion of the PAS-1 and HSDP (N.J.A.C. 10:60-1.14(a)). The number of hours of private duty nursing included in the service plan is based upon the recipient's medical need and the cost of service. The total cost of all services provided through ACCAP must be less than the cost of care in an appropriate institution. The need for private duty nursing services and the hours of private duty nursing services may increase or decrease as the recipient's medical status changes, and correspondingly, as the service cost cap changes.

3. (No change.)

4. Personal care assistant service: These are health-related tasks performed in the recipient's home by a certified individual who is under the supervision of a registered professional nurse. These services shall be prescribed by a physician and shall be provided in accord with a written plan of care. Personal care assistant services under ACCAP may exceed the [regular] maximum program limitation. Only Medicaid-approved personal care assistant providers shall provide personal care assistant service under ACCAP. **All personal care assistants must meet the requirements defined in N.J.A.C. 10:60-1.2.**

5. (No change.)

6. Specialized group foster care home for children: This allows for an array of health care services provided in a residential health care program for children from birth to [6] **18** years of age. All children served by the home are under the supervision of the Division of Youth and Family Services (DYFS). **Specialized group foster care home for children services must be prior authorized by the MDO staff, using the FD-352 form (see Appendix A, Fiscal Agent Billing Supplement).**

7. Hospice care: This provides optimum comfort measures (including pain control), support and dignity to recipients certified by an attending physician as terminally ill, with a life expectancy of up to six months. Family and/or other caregivers are also given support and direction while caring for the dying recipient. Services shall be provided by a Medicaid approved, Medicare certified hospice agency and available to a recipient on a daily, 24-hour basis. Hospice care shall be approved by the attending physician [and shall be prior authorized by the Medicaid District Office, using the FD-139 form (for recordkeeping requirements, see N.J.A.C. 10:60-2.3(b)5]. **Hospice services include: skilled nursing visits; hospice agency medical director services; medical social service visits; occupational therapy, physical therapy and speech-language pathology services; intravenous therapy; durable medical equipment; medication related to symptom control of terminal illness and case management.** Reimbursement shall be at an established fee paid on a per diem basis.

(b) Total program costs in ACCAP are limited by the number of community care slots used each year and by costs per recipient. The cost of [each] **those** recipient[']s' service packages shall be no more than the cost of institutional care for [that] **those** recipients, determined at a projected weighted cost of [hospital] **institutional** care by the Division of Medical Assistance and Health Services.

10:60-[3.16]**2.16** Basis for reimbursement for ACCAP services

(a) A fee-for-service reimbursement methodology shall be utilized for ACCAP waiver service.

(b) The Health Insurance Claim form, 1500 N.J., is used when requesting reimbursement for waiver services provided. [Home health services are billed using the UB-82 HCFA-1450 form.]

(c) See N.J.A.C. 10:60-[5]**4** for codes used when submitting claims for ACCAP.

SUBCHAPTER [4]**3.** HOME CARE EXPANSION PROGRAM

10:60-[4.1]**3.1** (No change in text.)

10:60-[4.2]**3.2** Eligibility requirement for HCEP

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

(d) [Applicants who are eligible for the Community Care Program for the Elderly and Disabled (CCPED) shall be eligible for HCEP if CCPED services are unavailable in the applicant's county of residence.] **An applicant who is eligible for the Community Care**

Program for the Elderly and Disabled (CCPED) shall be eligible for HCEP if CCPED services are unavailable in the applicant's county of residence.

1. When CCPED services are available in the applicant's county of residence, the applicant shall not be eligible for HCEP.

2. An applicant who is eligible for Medicaid services under the community standard, including New Jersey Care ... Special Medicaid Programs, is not eligible for HCEP.

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

10:60-[4.3]**3.3** Services available under HCEP

(a) The seven services provided under HCEP are:

1.-2. (No change.)

3. Homemaker: Personal care, household tasks, and activities of daily living, provided to a beneficiary in the home **by a certified homemaker-home health aide employed** by either a home health agency or a homemaker agency;

4.-7. (No change.)

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

Recodify existing N.J.A.C. 10:60-4.4 and 4.5 as **3.4 and 3.5** (No change in text.)

10:60-[4.6]**3.6** Termination from HCEP

(a) Beneficiaries shall be terminated from HCEP if:

1.-2. (No change.)

3. He or she is determined financially eligible for Medicaid benefits;

[3.]**4.** He or she is assessed as no longer in need of long-term home care services; [or]

[4.]**5.** His or her cost-share payments are not paid in full for two consecutive months[.]**; or**

6. He or she is determined eligible for CCPED and services are available in the applicant's county of residence.

(b) (No change.)

(c) A beneficiary terminated from HCEP shall be billed by the Bureau of Pharmaceutical Assistance to the Aged and Disabled for services rendered during a period [if] **of** ineligibility.

(d) (No change.)

(e) A beneficiary who is terminated from HCEP participation may exercise his or her right to appeal the decision by submitting a request for a fair hearing in accordance with N.J.A.C. 10:49-[5.3] **9.10**. Such request shall be submitted within 20 days from the date of the letter of termination.

1.-2. (No change.)

(f) (No change.)

SUBCHAPTER [5.]**4.** HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:60-[5.1]**4.1** (No change in text.)

10:60-[5.2]**4.2** HCPCS Codes

(a) (No change.)

(b) Community Care Program for the Elderly and Disabled (CCPED) and Home Care Expansion Program (HCEP)

HCPCS
CODE DESCRIPTION

Z1240 Case Management, per recipient, per month

1. The following codes are to be used by licensed Home Health Agencies ONLY

Z1245 to Z1339 (No change.)

2. The following codes may be used by licensed Home Health Agencies or Homemaker Agencies

Z1200 to Z1235 (No change.)

[90050]
W9002 Medical Day Care, daily

3. In addition to the above, the following are appropriate to HCEP only and used only by HCEP case managers

Z1202 Initial Comprehensive Needs Assessment

Z1203 Collection of Disability Information

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

SUBCHAPTER 6. (RESERVED)

APPENDIX A
FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Paramax/Unisys Corporation
CN 4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN 049
Trenton, New Jersey 08625-0049

(a)

DIVISION OF FAMILY DEVELOPMENT

Public Assistance Manual

Persons Eligible for Medical Assistance

Proposed Amendment: N.J.A.C. 10:81-8.22

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

Authority: N.J.S.A. 44:10-3.

Proposal Number: PRN 1993-293.

Submit comments by August 4, 1993 to:

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

The agency proposal follows:

Summary

The proposed amendment at N.J.A.C. 10:81-8.22 provides policy clarification to establish that the deemed income of the parent(s) of an adolescent parent is not to be used to determine Medicaid eligibility for dependent child(ren) of an adolescent parent. The proposed amendment stipulates that in the event an Aid to Family with Dependent Children (AFDC) eligible family unit is determined financially ineligible for AFDC cash assistance because of the inclusion of the deemed income of the parent(s) of the adolescent parent, the county welfare agency (CWA) shall determine AFDC categorically-related Medicaid eligibility for the dependent child(ren) of the adolescent parent without consideration of that deemed income. The dependent child(ren) shall be eligible for AFDC categorically-related Medicaid coverage as long as the family's countable income, excluding the deemed income of the parent(s) of the adolescent parent, is less than the AFDC standard applicable for the family size. In this instance, AFDC categorically-related Medicaid eligibility would be limited to the dependent child(ren) of the adolescent parent; the adolescent parent would remain ineligible for such Medicaid coverage. At N.J.A.C. 10:81-8.22(a), the term "Medicaid Only" has been replaced with "Medicaid coverage" in order to differentiate between AFDC categorically-related Medicaid eligibility and the Medicaid Only program which is now under the jurisdiction of this Department's Division of Medical Assistance and Health Services. An aged, blind or disabled person who desires Medicaid and does not wish to receive a money payment may apply for the Medicaid Only program. Such rules are found at N.J.A.C. 10:71.

Social Impact

The proposed amendment would provide Medicaid eligibility for certain children who would otherwise be ineligible in situations where an AFDC eligible family unit is determined financially ineligible for AFDC cash assistance because of the inclusion of the deemed income of the parent(s) of the adolescent parent in the financial eligibility process.

Economic Impact

The economic impact is anticipated to be minimal. The following estimates are based on 1986 AFDC caseload statistics increased for caseload growth. It should be noted that the majority of those potentially impacted are not currently on AFDC. There is no data, however, to estimate this population. It is assumed that five percent of teenage mothers on their parent's grant have earned income and that two children per mother are anticipated to be eligible for assistance. The average monthly cost per child is provided by the Division of Medical Assistance and Health Services.

Estimated Number of Children	Average Monthly Cost Per Child	Monthly Cost	Annual Cost
44	$395.00	$17,222	$206,664

Regulatory Flexibility Statement

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

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

10:81-8.22 Persons eligible for medical assistance

(a) All children and their parents or needy parent-persons who are eligible for AFDC money payments (-C, -F and -N segments), or no money payments due to the provisions of N.J.A.C. 10:82-11, are eligible for Medicaid benefits. If an eligible unit chooses not to receive a money payment, members are eligible for Medicaid [Only] **coverage**. Medicaid coverage commences with the date that eligibility is established.

1.-2. (No change.)

3. When a family is determined financially ineligible for AFDC cash assistance due to deeming of the income of the parent(s) of an adolescent parent in accordance with N.J.A.C. 10:82-3.14, the dependent child(ren) of the adolescent parent shall be or continue to be eligible for AFDC categorically-related Medicaid coverage as long as the family's countable income, excluding the deemed income of the parent(s) of the adolescent parent, is less than the AFDC eligibility standard set forth at N.J.A.C. 10:82-1.2(b), Schedule II, as applicable for the family size. Medicaid eligibility, in such instances, would be limited to the dependent child(ren) of the adolescent parent; the adolescent parent, therefore, would remain ineligible for such Medicaid coverage.

(b)-(g) (No change.)

(a)

DIVISION OF FAMILY DEVELOPMENT
Office of Child Support and Paternity Programs
Public Assistance Manual
Review and Adjustment of Non-AFDC Child Support Orders
Proposed Amendments: N.J.A.C. 10:81-11.7 and 11.9

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

Authority: N.J.S.A. 44:10-3, Family Support Act of 1988 (Public Law 100-485), Section 103(c); 45 C.F.R. 303.8.

Proposal Number: PRN 1993-241.

Submit comments by August 4, 1993, to:
Marion E. Reitz, Director
Division of Family Development
CN 716
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendments at N.J.A.C. 10:81-11.7(b) and 11.9(l)4i set forth the procedures for the review and adjustment of non-AFDC child support orders. The Family Support Act (P.L. 100-485) mandates that states must have a plan for reviewing all IV-D child support orders to determine if an adjustment is necessary. In New Jersey, this review is performed by the Office of Child Support and Paternity Programs. Both parties to a current child support order, in which the client is not receiving public assistance, will receive a notice advising them of their right to request a review. Those requesting a review will be instructed to respond to the Office of Child Support and Paternity Programs (OCSPP) within 30 days of the notice. Those cases in which either party has requested a review may be eliminated from the review if the current order is less than three years old and a request for review has been determined to be frivolous by the IV-D agency, the OCSPP. A request would be considered frivolous under the following circumstances:

1. Either party's income has not increased or decreased by a minimum of 20 percent;
2. Either party is temporarily out of work, incarcerated or institutionalized;
3. The child(ren) for whom support is owed no longer lives with the custodial parent; or
4. There is a good cause determination that the review of the case is not in the best interest of the child.

Regarding those cases eligible for a review, the need for an adjustment to the order will be determined by using the income and expense information of both parties and calculating the appropriate order amount determined by the New Jersey Child Support Guidelines. If the calculation is 20 percent over or under the current order, an adjustment is warranted. The order will also be adjusted for medical support if medical support is not part of the current order. When an adjustment is warranted, attorneys will be hired by OCSPP to perform the necessary court functions.

The proposed amendment at N.J.A.C. 10:81-11.9(d)1ii, which indicates that the consent conference is heard before a Family Division Intake Officer, is a technical amendment. This amendment is being made in order that the correct title of the individual holding the consent conference will be referenced.

The proposed amendment at N.J.A.C. 10:81-11.9(l)4i, concerning the reference to "non-AFDC cases", was added to clarify that such services are also available to non-AFDC clients, as outlined at N.J.A.C. 10:81-11.9(b).

Social Impact

The proposed amendments at N.J.A.C. 10:81-11.7(b) and 11.9(l)4i, which require review and adjustment of child support orders for non-AFDC cases, reflect continued concern for children by providing that a minimum standard of living for the child will continue to increase proportionately to that of both parents. The use of the child support guidelines in the review will ensure equitable treatment of all individuals party to a child support order. The impact to the OCSPP will be moderate. Two current child support specialists have been assigned to the project.

No impact is expected from the technical change proposed at N.J.A.C. 10:81-11.9(d)1ii.

Economic Impact

The review and adjustment of child support orders is expected to have a positive economic impact by preventing a decline in the value of the support order due to inflation, which is often the case over time as the monetary amount of the order does not keep up with inflation. In a pilot study, completed by the Office of Child Support and Paternity Programs in December 1987, a review of 2,331 cases was done. As a result of this review, orders were adjusted totaling an additional $7,483,385, with an average order going from $26.85 per week to $61.74 per week, which is approximately a 130 percent increase. The implementation of these procedures with regard to the hiring of attorneys when an adjustment is warranted, is expected to increase costs of the OCSPP. However, the money has been allotted in the State IV-D office budget, and is reimbursable through Federal financial participation at the rate of 66 percent.

No impact is expected from the technical change proposed at N.J.A.C. 10:81-11.9(d)1ii.

Regulatory Flexibility Statement

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

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

10:81-11.7 Responsibilities of the State agency

(a) (No change.)

(b) Federal law mandates that the State must have a written and publicly available plan indicating how and when IV-D child support orders in effect in the State will be periodically reviewed and adjusted. Non-AFDC, IV-D child support orders will be processed by the Office of Child Support and Paternity Programs (OCSPP) for review as provided for in this subsection.

1. An adjustment is an upward or downward change in the amount of child support, based on the application of State guidelines under New Jersey Court Rule 5:6A for setting and adjusting child support awards, and/or a provision for the child's health care needs through health insurance coverage or other means.

2. Review means an objective evaluation of information, conducted by the OCSPP, making it necessary for application of New Jersey Child Support guidelines, Court Rule 5:6A, to determine:

i. The appropriate support award amount; and

ii. The need to provide for the child's health care needs in the order, through health insurance coverage or other means.

3. Case identification procedures are as follows:

i. Written notice will be given by the OCSPP, advising both parties to a current child support order of their right to request a review within 30 days of the date of the notice.

ii. Those requesting a review will be instructed to write to the OCSPP.

iii. Upon receipt of the request for review, the OCSPP will establish a file. Written notice will be issued to both parties advising that a review of their current order will commence 30 days from the date of the notice, or that no review will be conducted because the request was not made timely within 30 days of the receipt of the identification notice.

iv. A request for information will be mailed to the individual qualifying for a review. The case file will be referenced by obligor's last name, first name, obligee's name and ACSES case number.

v. Upon receiving return responses to initiate the review, qualified cases shall be processed by OCSPP, which shall:

(1) Verify parties' employment and income through an interface with the New Jersey Department of Labor (DOL);

(2) Cross reference the case on ACSES to determine if multiple cases exist (the amount of the obligor's court order(s) in other cases will be considered in accordance with the State guidelines);

(3) Generate employment letters to the last known employer and/or any new employer information received on the parties; and

(4) Generate postal verification letters to the last known address of the parties and/or any new address information received.

4. A case can be eliminated from the review process if it is found that:

i. The current order is less than three years old or a request for review has been determined frivolous by the OCSPP. A frivolous request would exist if any one of the following occurs:

(1) If either party's income has not increased or decreased by a minimum of 20 percent;

(2) If either party is temporarily out of work or temporarily injured and unable to work;

(3) The child(ren) for whom support is owed no longer resides with the custodial parent;

(4) If either party is incarcerated or institutionalized; or

(5) There is a good cause determination that the review of the case is not in the best interest of the child(ren).

ii. If a case has been eliminated from the review process, a notation shall be made in the file on the "Adjustment of Review Document," indicating the date of the review and the reason(s) for eliminating the case from the adjustment work list.

5. When all needed information is obtained, calculations using both parents' income and the New Jersey Child Support Guidelines, Court Rule 5:6A, will be formulated to determine the anticipated child support order. OCSPP will compare the amount to the current child support order.

6. No adjustment will be initiated if calculations determine the adjusted amount is not 20 percent over or under the current order.

i. A written notice will be issued to both parties advising that, as a result of the review, the case does not qualify for an adjustment; and if either party disagrees, he or she has 30 days to file a request for redetermination. The notice shall also advise the parties that a redetermination may be filed only if information on which the determination was made was incorrect or incomplete.

7. If calculations determine that the adjusted amount is 20 percent over or under the current order, or if medical support is not currently in the order, a notice of adjustment will be sent to both parties advising of the new amount as a result of the review. Both parties have 30 days to request a redetermination of the decision, or either party may file the appropriate application with the court.

10:81-11.9 Responsibilities of the CWA/CSP Unit

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

(d) Legal action taken by the CSP Unit: If the CSP Unit collects information sufficient to locate the absent parent, legal proceedings shall be initiated for the purpose of establishing paternity and/or obtaining support and medical insurance within 90 working days of location. Each county welfare agency is required to have attorneys, all of which hold a plenary license to practice law in this State, who are in good standing and maintain a bona fide office for the practice of law in this State, either on staff or under contract, sufficient to represent the CWA in child support enforcement matters in court as necessary.

1. Consent process: For all cases in which sufficient information is available to initiate proceedings for the purpose of establishing paternity and/or obtaining support and medical insurance, a consent order will be attempted in accordance with individual county procedures within 90 calendar days of location.

i. (No change.)

ii. Definition: The consent process is a conference between the plaintiff and the defendant before a [hearing officer] **Family Division Intake Officer,** to agree to a specific amount of child support based on an approved support formula, **as outlined in the New Jersey Child Support Guidelines, Court Rule 5:6A,** to be paid through the appropriate probation department.

iii. (No change.)

2.-10. (No change.)

(e)-(k) (No change.)

(l) Title IV-D services available to non-public assistance persons: Appropriate child support services are to be made available to non-public assistance persons upon application filed by such individual with the IV-D Agency. These services shall include locating obligors, establishing paternity and securing support and medical insurance.

1.-3. (No change.)

4. Obtaining an order: Non-public assistance persons seeking support payments and medical insurance shall be referred to the county intake unit responsible for initiating consent conference.

i. Once an order has been established, non-AFDC cases will be processed for review and adjustment as outlined at (b) above.

5. (No change.)

(a)

DIVISION OF FAMILY DEVELOPMENT

Public Assistance Manual
Review and Adjustment of Child Support Orders (AFDC, Foster Care and Medicaid Only Cases)

Proposed New Rule: N.J.A.C. 10:81-11.21

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

Authority: N.J.S.A. 44:10-3, Family Support Act of 1988 (Public Law 100-485), Section 103, and 45 C.F.R. 303.8.

Proposal Number: PRN 1993-373.

Submit comments by August 4, 1993 to:
Marion E. Reitz, Director
Division of Family Development
CN 716
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed new rule at N.J.A.C. 10:81-11.21 outlines procedures for the review and adjustment of Aid to Families with Dependent Children (AFDC), foster care and Medicaid Only cases. The Family Support Act (P.L.100-485) mandates that states must have a plan for reviewing all child support orders to determine if an adjustment is necessary. Under this plan, all AFDC IV-D cases will be reviewed once every three years.

The County Welfare Agency/Child Support and Paternity (CWA/CSP) Unit will review all appropriate cases at least once every three years or at the request of either parent subject to the order for possible adjustment. The review will be based on an Automated Child Support Enforcement Systems (ACSES) generated report, which will identify cases with orders that have not been reviewed for two years and 11 months. The CWA/CSP Unit will screen the cases on the report to identify those cases that require an adjustment to an order to bring it into compliance with New Jersey's Child Support Guidelines as set forth in New Jersey Court Rule 5:6A.

The procedures for the review of cases will consist of the development of an ACSES report to identify appropriate cases for review for possible adjustment; screening of cases on the report to identify those cases that should be adjusted; provisions for the elimination of cases that have been determined to have good cause or are less than three years old or have been reviewed in the last three years; updating the review date field on the USM1 and USM2 screens and documenting why a case was eliminated from the adjustment cycle; provisions for the review of interstate cases where New Jersey is the initiating state; and provisions for the review of interstate cases where another state has determined that a review of a case is necessary.

The processing of cases for review by the CWA/CSP shall consist of: verifying information on obligor's current income, employment and medical insurance; cross-referencing the case on ACSES to determine if multiple cases exist; verification of obligors' address; and where medical support is not currently ordered, filing a motion to have the order adjusted to include medical support.

Recommendations for adjustment shall be based on the New Jersey Child Support Guidelines, New Jersey Court Rule 5:6A. If the recommended amount of adjustment is a 20 percent or more increase over the current order, a motion shall be filed to have the order modified. If the recommended amount of adjustment is a 20 percent or more decrease, the obligor should be directed to file appropriate application with the court.

Social Impact

The proposed new rule requiring the review of child support orders reflects continued concern for children by providing that a minimum standard of living for the child will continue to increase proportionately to that of the non-custodial parent. The use of the child support guidelines in the review will ensure equitable treatment of the obligor.

Economic Impact

The review of child support orders is expected to have a positive economic impact by preventing a decline in the value of the support order, as is often the case due to time and inflation. In a pilot study, completed by the Office of Child Support and Paternity Programs in December, 1987, a review of 2,331 cases was done. As a result of this review, orders were modified totaling an additional $7,483,385, with an average order going from $26.85 per week to $61.74 per week, which is approximately a 130 percent increase. In some cases, the increase of support orders will allow families to go off welfare.

Regulatory Flexibility Statement

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

Full text of the new rule follows:

10:81-11.21 Review and adjustment of child support orders (AFDC, foster care and Medicaid Only cases)

(a) The CWA/CSP Unit shall review all AFDC, foster care and Medicaid Only cases with a court order at least once every three years, or at the request of either parent subject to the order, for possible adjustment. If a request for review is made before the three year time frame, and the request is detemined to be frivolous by the CWA/CSP Unit, the request may be denied.

1. An adjustment is an upward or downward change in the amount of child support based upon an application of State guidelines under New Jersey Court Rule 5:6A for setting and adjusting child support awards and/or provision for the child's health care needs, through health insurance coverage or other means.

2. Review means an objective evaluation by the CWA/CSP Unit of information necessary for application of the New Jersey Child Support Guidelines, New Jersey Court Rule 5:6A, to determine:

i. The appropriate support award amount; and

ii. The need to provide for the child's health care needs, through health insurance coverage or other means.

3. Examples of a frivolous request would be as follows:

i. An obligor's income has not increased or decreased by a minimum of 20 percent.

ii. An obligor is temporarily out of work or temporarily injured and unable to work.

(b) The procedure for the review of cases shall be as follows:

1. An Automated Child Support Enforcement Systems (ACSES) report has been developed to identify appropriate cases for review for possible adjustment. The review date field on the ACSES USM1 and USM2 screens will trigger a report of cases in which the date is equal to or greater than two years and 11 months from the run date of the report.

2. The CWA/CSP shall screen cases on the report to identify those cases that should be adjusted to bring them into compliance with the Child Support Guidelines at New Jersey Court Rule 5:6A.

3. A case can be eliminated from the screening if it is found that:

i. There is a good cause determination that the review of the case is not in the best interest of the child(ren);

ii. The current order is less than three years old or the case has been reviewed in the last three years, unless a review was requested by either parent subject to the order and it has not been determined to be a frivolous request by the CWA/CSP Unit. Examples of a frivolous request would be as outlined in (a)3 above; or

iii. The obligor is institutionalized.

4. The review date filed on the USM1 and USM2 shall be updated indicating the date that a review was completed. If the case was eliminated from the adjustment cycle, the reason should be documented.

i. The CWA/CSP shall determine within 15 calendar days after October 13, 1993, or the date the child support order is 36 months old, whichever is later, whether a review should be conducted.

ii. In handling a request for a review, the CWA/CSP has up to 15 calendar days from the receipt of a request to determine whether a review should be conducted.

iii. Within 180 calendar days of determining that a review should be conducted or locating the non-requesting parent, whichever occurs later, the State must complete the process by adjusting the order

or determining the order should not be adjusted and completing the steps outlined at (c) and (d)1 through 4 below.

iv. Interstate cases should also follow the 180 calendar day timeframe for completing the review and adjustment process.

5. When it is determined that a review should be conducted on an interstate case and New Jersey is the initiating state, a request for review shall be sent to the responding state within 20 calendar days of receipt of sufficient information to conduct a review.

i. The information the responding state needs to act on the request must be provided.

ii. If the request for review is the first contact between the initiating and responding states in the case, the initiating state must send the request for review to the interstate central registry in the responding state.

iii. If the initiating state has previously referred the case to a responding state for action, the request for review may be sent directly to the appropriate agency in the responding state for processing.

iv. The initiating state is also responsible for sending to the parent in its state a copy of any notice issued by a responding state in connection with the review and adjustment of an order. This notice must be sent to the parent within five working days of receipt in the initiating state.

6. When acting as the responding state in a case which another state has determined a review is necessary, the laws and procedures for review and adjustment of the responding state apply. This includes the use of the responding state's child support guidelines.

i. Within 15 calendar days of receipt of a request for review from another state, a determination must be made as to whether or not the review will be conducted.

ii. The determination not to conduct a review because it would not be in the best interest of the child cannot be made by the responding state. This determination must be made by the initiating state.

(c) The CWA/CSP shall process cases for review in the following manner:

1. Information on the obligor's current income and employment should be obtained via the USM2 screen and/or on-line access to the Department of Labor's Wage Reporting File through the Honeywell terminals. Information obtained will be verified through a letter generated to the employer. Medical insurance information shall also be verified.

2. The case shall be cross-referenced on ACSES to determine if multiple cases exist (the amount of the obligor's court orders will figure in the use of the guidelines).

3. Verification of the obligor's address shall also be obtained.

4. In cases where there has been no change in the income, however, medical support is not currently ordered, a motion shall be filed to have the order adjusted to include medical support when health insurance is available to the obligor at a reasonable cost. If health insurance is not available to the obligor at a reasonable cost at the time of the modification, this order for support will go into effect when health insurance at a reasonable cost is actually available.

i. Health insurance is considered reasonable in cost if it is employment related or other group health insurance, regardless of service delivery mechanism.

(d) Recommendations for adjustment shall be based on the New Jersey Child Support Guidelines, New Jersey Court Rule 5:6A.

1. If the recommended amount of adjustment is a 20 percent or more increase over the current order, a motion shall be filed to have the order modified.

2. If the recommended amount of adjustment is a 20 percent or more decrease, the obligor should be directed to file appropriate application with the court.

3. Each parent subject to a child support order shall be notified of any review of the order at least 30 calendar days before commencement of the review.

i. This notification requirement may be satisfied by filing a notice of motion, provided both parties are notified 30 calendar days prior to the hearing.

ii. If modification is warranted, the notice of motion may serve as a notice to both parties of the review determination. If either party disagrees with the determination, they may challenge the decision to a judge. If no adjustment is warranted based on a review, a notice shall be issued as outlined in (d)4i and ii below.

4. Following any review the CWA/CSP shall notify each parent subject to the child support order of the following:

i. Any adjustment or a determination that there should be no change; and

ii. Each parent's right to initiate proceedings to challenge the adjustment or determination within 30 calendar days after the date of the notice.

(e) The CWA Statistical Report shall be completed each month to reflect the number of cases reviewed and the number of cases adjusted.

(f) The Family Support Act of 1988 (Public Law 100-485), Section 103(c), mandates that between October 13, 1990 and October 13, 1993 the CWA/CSP Unit must target for review and adjustment, if appropriate, the existing IV-D cases in which support is assigned to the county welfare agency and which have not been reviewed or adjusted within 36 months. These cases shall be addressed by reviewing one-third of the caseload per year, over a three year period.

(a)

DIVISION OF FAMILY DEVELOPMENT

Assistance Standards Handbook

Deeming Income of Parents and Guardians of Adolescent Parents

Proposed Amendment: N.J.A.C. 10:82-3.14

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

Authority: N.J.S.A. 44:10-3.

Proposal Number: PRN 1993-295.

Submit comments by August 4, 1993 to:
Marion E. Reitz, Director
Division of Family Development
CN 716
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendment at N.J.A.C. 10:82-3.14 serves to make reference to text proposed elsewhere in this issue of the New Jersey Register at N.J.A.C. 10:81-8.22 concerning the determination of Medicaid eligibility for dependent child(ren) of an adolescent parent without consideration of the deemed income of the parent(s) of an adolescent parent. In accordance with N.J.A.C. 10:81-8.22, dependent child(ren) are eligible for Aid to Families with Dependent Children (AFDC) categorically-related Medicaid coverage as long as the family's countable income, excluding the deemed income of the parent(s) of the adolescent parent, is less than the AFDC standard applicable for the family size.

Social Impact

The proposed amendment has no social impact in and of itself, as it serves only to refer to N.J.A.C. 10:81-8.22 (proposed for amendment elsewhere in this issue of the New Jersey Register) continuing Medicaid eligibility for dependent child(ren) of an adolescent parent, the deeming of whose parent(s)' income renders the family ineligible for AFDC cash assistance. The social impact of N.J.A.C. 10:81-8.22 is as set forth in that proposal.

Economic Impact

The proposed amendment has no economic impact in and of itself, as it serves only to refer to N.J.A.C. 10:81-8.22 (proposed for amendment elsewhere in this issue of the New Jersey Register) continuing Medicaid eligibility for dependent child(ren) of an adolescent parent, the deeming of whose parent(s)' income renders the family ineligible for AFDC cash assistance. The economic impact of N.J.A.C. 10:81-8.22 is as set forth in that proposal.

Regulatory Flexibility Statement

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

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

10:82-3.14 Deeming income of parents and guardians of adolescent parents

(a) (No change.)

(b) When an adolescent parent lives in the same home as his or her own parent(s) or legal guardian(s), the income of such parent(s) or legal guardian(s) shall be considered available to the eligible family in accordance with the following procedures. These rules do not apply if the parent(s) or guardian(s) receive(s) SSI or AFDC or if the adolescent parent is categorically eligible for the -N segment only. For the purposes of this section, the term parent shall include legal guardian.

1.-5. (No change.)

6. All income remaining shall be counted as unearned income available to the eligible unit and shall be counted toward total income (N.J.A.C. 10:82-1.2) and in the determination of grant amount.

i. In the event the eligible family unit is determined financially ineligible for AFDC cash assistance due to the inclusion of such deemed income, Medicaid eligibility for the dependent child(ren) of the adolescent parent shall be determined in accordance with N.J.A.C. 10:81-8.22(a)3.

(c) (No change.)

CORRECTIONS

(a)

THE COMMISSIONER

Transportation of Inmates
Recall to Court

Proposed Amendment: N.J.A.C. 10A:3-9.6

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

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

Proposal Number: PRN 1993-354.

Submit comments by August 4, 1993 to:
William H. Fauver, Commissioner
Department of Corrections
CN 863
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Currently, a writ of habeas corpus, writ of habeas corpus ad testificandum, post conviction relief order, or other order to produce an inmate must be received from the courts at a correctional facility 24 hours prior to the scheduled court appearance. This amendment will change the required time period from 24 hours to 48 hours. The additional time period is necessary to accommodate the efficient handling and processing of a writ to produce an inmate. Work schedules for correction officers who transport inmates are completed and promulgated 24 hours in advance. Correction officer notification and scheduling difficulties arise when writs to produce inmates arrive at the correctional facility concurrent with or subsequent to the promulgation of custody officers' work schedules. This proposed amendment will ensure the timely handling of writs to produce inmates in conjunction with the required scheduling, processing and notification of correction officers assigned to transport inmates.

Social Impact

The unnecessarily short time frame for processing of writs to produce inmates and the re-scheduling of correction officers to transport inmates increases the possibility of unintentional errors, stress and pressure. The proposed amendment will provide correctional facility staff an additional time period that will ensure an efficient procedure to process writs to produce inmates and schedule and notify correction officers assigned to transport inmates. Currently, the Administrative Office of the Courts has arranged for the correctional facility receipt of writs to produce inmates within a minimum of 48 hours in advance, hence a negative social reaction is not anticipated.

Economic Impact

Although it is difficult to gauge the full economic impact of this proposed amendment, it is probable that a decrease in overtime staff hours will result. With the increase of time from 24 to 48 hours for the correctional facility receipt of writs to produce inmates, more time will be available to process these writs during normal working hours. Additionally, custody offices can be scheduled to transport inmates in a more efficient and timely manner. Additional State financial resources will not be necessary to implement or maintain this amendment.

Regulatory Flexibility Statement

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

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

10A:3-9.6 Recall to court

(a) An inmate shall only be produced in court by a writ of habeas corpus, writ of habeas corpus ad testificandum, post conviction relief order, or other order to produce which is to be at the correctional facility [24] **48** hours prior to the scheduled court appearance.

1.-4. (No change.)

(b) (No change.)

INSURANCE

(b)

DIVISION OF FINANCIAL EXAMINATIONS

Financial Examinations Monitoring System
Data Submission Requirements for All Domestic Insurers

Proposed Amendments: N.J.A.C. 11:19-2.2 and 2.3
Proposed New Rules: N.J.A.C. 11:19-2.5 and Appendix B

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

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), 17:23-1 et seq. and 17B:21-1 et seq.

Proposal Number: PRN 1993-355.

Submit comments by August 4, 1993 to:
Verice M. Mason
Assistant Commissioner
New Jersey Department of Insurance
Legislative and Regulatory Affairs
20 West State Street
CN 325
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Insurance ("Department") is responsible for monitoring the financial solvency of approximately 1,600 insurance and other risk assuming entities. In order to streamline the current manual, labor intensive regulatory process involved in carrying out this

responsibility, the Department, with the help of the New Jersey Office of Telecommunications and Information Systems ("OTIS"), has designed and is in the process of implementing a multi-faceted automated Financial Examination Monitoring System ("FEMS"). The Department is proposing a series of rules intended to set forth the data elements, format and filing requirements by which insurers and related entities will submit data to the Department for use in FEMS. On May 11, 1992 the Department issued Bulletin No. 92-14 which provided insurers and other related entities affected by FEMS with a brief overview of the project. The Department has already adopted one FEMS subsystem: N.J.A.C. 11:19-2, the Investment Valuation Subsystem ("IVS") (see 25 N.J.R. 591(a)); and has proposed N.J.A.C. 11:19-3, the Surplus Lines Processing Subsystem ("SLPS") (see 24 N.J.R. 3003(a)).

FEMS was designed with several objectives in mind: to improve the Department's ability to identify and react to financially troubled insurers in a timely manner; to improve the overall quality and effectiveness of the Department's surveillance procedures; to provide up-to-date financial data for company analysis as soon as it is available; to reduce or eliminate rote number crunching and cross-checking activities so that examiners may spend more time on solvency analysis and less on compliance testing; to design a system that can accommodate yearly changes in data and analytical tests without significant reprogramming; and to be consistent with the National Association of Insurance Commissioners ("NAIC") automation plans.

These proposed rules are the third in a series of proposals that will set forth the data elements, format and filing requirements by which insurers submit data to the Department for use in FEMS. These proposed amendments and new rules specifically implement the General Ledger Analytical Review Subsystem ("GLARS").

GLARS is an exam productivity tool which generates trial balances and lead sheets from company ledger detail and annual statement filings. It allows examiners to load data, produce financial statements, and generate lead sheets. GLARS' objectives are as follows:

1. To provide the Department with an automated facility to input and analyze detailed account information from an individual insurance company's general ledger; and
2. To improve the efficiency of the examination process by improving the accuracy and quality of general ledger financial analysis, trend analysis and analytical review.

GLARS will also be able to interface with the NAIC's data base.

A summary of the various provisions of the proposed amendments and new rules follows:

N.J.A.C. 11:19-2.2 is amended to add a definition of "ASCII."

N.J.A.C. 11:19-2.3 is amended to change the "Appendix A" reference to "Appendices" found in the general data filing requirements for all domestic insurers.

Proposed new rule N.J.A.C. 11:19-2.5 provides the subsystem filing requirements for GLARS.

Proposed Appendix B provides, in four Exhibits, the General Ledger Account Detail Record Layout, the General Ledger Account Detail Record Layout Description, the Adjusting Entry Detail Record Layout and the Adjusting Entry Detail Record Layout Description.

Social Impact

The proposed amendments and new rules have a beneficial social impact. The Department is charged with the responsibility of monitoring all insurance companies authorized to do business in New Jersey in order to protect policyholders by determining the solvency of these insurers. The task to monitor the solvency of insurers is performed mainly by the Department's Financial Examinations Division and the Division of Actuarial Services. Due to the lack of automated systems, these Divisions presently have to carry out their functions primarily in a manual fashion. The Department believes that in order to regulate the very large and highly automated insurance industry, it is necessary for its Divisions to be supported by state-of-the-art, transaction-oriented systems.

By using state-of-the-art, transaction-oriented systems, the Department can more effectively monitor the financial condition of insurance companies under its jurisdiction and act to avert impairments or insolvencies by recommending remedial action.

Economic Impact

These proposed amendments and new rules will impact the Department and domestic insurers and related entities required to submit data for use in FEMS.

In order to carry out its fiscal responsibility to monitor the financial solvency of approximately 1,600 insurance companies and other risk assuming entities, most of which are highly automated, the Department implemented the FEMS System. The Department believes that it is important to provide its Financial Examinations Division and the Division of Actuarial Services with a computer system which will increase the Department's ability to perform its duty of monitoring the financial solvency of insurance companies. The Department has already expended funds in order to develop the FEMS System.

As a result of these proposed new rules, domestic insurers will be required to submit information to the Department in the format specified by these rules. Insurers may incur costs in connection with assimilating, preparing and supplying the required information. Insurers will incur costs to develop the system. These costs will vary greatly from insurer to insurer depending on the nature of their existing information systems and the extent of programming changes that are necessitated to comply with these proposed new rules. For this reason, the Department can not quantify with any degree of certainty the cost that will be incurred by an individual insurance company.

Insurers presently pay for regular examinations and incur costs in submitting that data. The Department believes that insurer's incurred costs as a result of the rules will be offset or reduced by more efficient, automated systems. Some insurers may find costs of examinations reduced.

These rules will improve the Department's ability to better monitor the financial solvency of a company which is beneficial to the public.

Regulatory Flexibility Analysis

These proposed new rules impose compliance requirements on domestic insurance companies formed under the laws of this State, some of which may be small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The Department is unable practically or reliably to estimate the costs that will be incurred or the need for professional services that may be required by small businesses to comply with these rules. The costs and need for services will vary substantially depending upon each insurer's internal resources. These rules do not change the data reporting requirements for affected companies, but only the manner in which the data is reported. In order to effectuate the goals of these rules, no differentiation in requirements based upon business size can be provided.

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

11:19-2.2 Definitions

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

...

"ASCII" means the American Standard Code for Information Interchange. It is a byte-oriented coding system based on an eight bit code and used primarily to format information for transfer in a data communications environment.

...

11:19-2.3 General data filing requirements for all domestic insurers

(a) All domestic insurers shall file with the Department on an annual basis the information required by this subchapter for the prior calendar year ending December 31 by January 31, of the next year, in accordance with [Appendix A] **the Appendices** to this subchapter incorporated herein by reference. Data for 1992 shall be filed by March 1, 1993.

(b) (No change.)

11:19-2.5 GLARS subsystem filing requirements

(a) All domestic property and casualty and life/health insurance companies shall provide the Department with a report on their pre-closing general ledger account balances and year-end closing adjustments for this State on a personal computer diskette in accordance with (b) and (c) below.

(b) A personal computer diskette shall be formatted so that it can be read by an IBM or compatible personal computer. The diskette must be a high density, double-sided, 1.44 megabyte (3.5 inch) or 1.2 megabyte (5.25 inch) diskette (3.5 inch diskettes are preferred).

1. The file shall be a non-delimited ASCII text file with a carriage return and line feed as the last character of each record. The data shall not be in compressed format.

2. The file shall be named using the company type (P for property and casualty, L for life/health), year (92, 93 etc.), the company NAIC number, and an ASC extension (for ASCII). For example, the 1992 file for a property and casualty company with an NAIC number of 12345 would be named P9212345.ASC.

(c) All reports on pre-closing general ledger account balances and year-end closing adjustments filed by domestic property and casualty and life/health insurance companies with the Department shall include the information and be submitted in the format set forth in the record layouts in Appendix B to this subchapter which is incorporated in this rule by reference. The report shall include the following information:

1. An external label shall be affixed to diskette(s) and include the following information:

i. The company's name and NAIC number, type (P&C for property and casualty or L/H for life/health), and year of the data (for example, 1992);

ii. The date when the diskette was mailed;

iii. The volume sequence number of the diskette (for example, "1 of 1" or "2 of 4");

iv. The volume serial number of the diskette (this can be determined by executing the DOS "VOL" command); and

v. The information shall be displayed as follows:
NAME: (for example, ABC Life Ins. Co.)
NAIC NO: NNNNN
TYPE: (for example, L/H)
YEAR OF DATA: YY
DATE MAILED: MM/DD/YY
DISK: 1 of 1
VSN: (for example, 2364-07E1);

2. A cover letter that provides the same information as on the external labels;

3. A signed affidavit by the insurer which shall accompany all transmissions attesting to the accuracy of the diskette(s); and

4. The diskette(s) may be delivered or mailed but shall be received by the Department by January 31 at the following address:
New Jersey Department of Insurance
FEMS—General Ledger System Project
20 West State Street
CN 325
Trenton, New Jersey 08625-0325

APPENDIX B
Exhibit 1
General Ledger Account Detail Record Layout

Field Number	Field Name	Start Pos	Field Type and Length	Comments
1	General Ledger Account Number	1	X(12)	General Ledger account number including sub-accounts.
2	Adjustment Number	13	9(5)	Must be "0", right justified.
3	Account Description	18	X(45)	Description of the account.
4	Annual Statement Page Number	63	X(2)	The page number of the annual statement where the account is reported.
5	Annual Statement Line Number	65	X(6)	The line number on the page where the account is reported.
6	Annual Statement Page Number	71	X(1)	The column number on the page where the account is reported.
7	Amount	72	9(16)	The amount of the year-end, preclosing account balance.
			87	

Note:
X = denotes alphanumeric
9 = denotes numeric

APPENDIX B
Exhibit 2
General Ledger Account Detail Record Layout Description

Field Number	Field Name	Comments
1	General Ledger Account Number	General ledger account number (alphanumeric, left justified, up to 12 positions). Sub-accounts are to be combined with account number, up to 12 positions.
2	Adjustment Number	A zero for the adjustment number (numeric, right justified) indicates this is an account and not an adjustment.
3	Account Description	Description of the account (the first 45 positions, left justified).
4	Annual Statement Page Number	The page number of the annual statement where the account is reported (must be 03, 04, or 12 for P&C companies or 03, 04, or 18 for L/H companies).
5	Annual Statement Line Number	The line number on the page where the account is reported (left justified, with a leading zero for numbers less than 10, that is, 02.2).
6	Annual Statement Column Number	The column number on the page where the account is reported (1 for pages 03 and 04; 1, 2, or 3 for page 12 or page 18).
7	Amount	The amount field will be the year-end pre-closing account balance (positive for debit balance and negative for credit balance). The decimal point is to be contained in the field. A leading minus ("-"), placed directly before the first number, is used to indicate negative numbers. Leading zeros are not to be used, but trailing zeros are to be used for the decimal places. The total field width (16) includes all numbers, the minus sign and the decimal point. For example, a negative $304,020 and 20 cents would appear as _____-304020.20, where the underscore represents spaces.

APPENDIX B
Exhibit 3
Adjusting Ledger Detail Record Layout

Field Number	Field Name	Start Pos	Field Type and Length	Comments
1	General Ledger Account Number	1	X(12)	General ledger account number to be adjusted.
2	Adjustment Number	13	9(5)	The adjustment number.
3	Adjustment Description	18	X(45)	Description of the adjustment.
4	Annual Statement Page Number	63	X(2)	The page number of the annual statement where the adjustment is reported.
5	Annual Statement Line Number	65	X(6)	The line number on the page where the adjustment is reported.
6	Annual Statement Column Number	71	X(1)	The column number on the page where the adjustment is reported.
7	Amount	72	9(16)	The year-end closing adjustment amount.
			87	

Note:
X = denotes alphanumeric
9 = denotes numeric

APPENDIX B
Exhibit 4
Adjusting Entry Detail Record Layout Description

Field Number	Field Name	Comments
1	General Ledger Account Number	General ledger account number to be adjusted (alphanumeric, left justified, up to 12 positions). If there is no account number for Surplus (page 03, line 25B for P&C companies and page 03, line 34 for L/H companies), account number 999 is to be used.
2	Adjustment Number	The same adjustment number should be used for all off-setting entries. All adjustment numbers shall be less than 90,000.
3	Adjustment Description	Description of the adjustment (The first 45 positions, left justified).
4	Annual Statement Page Number	The page number of the annual statement where the adjustment is reported (must be 03, 04, or 12 for P&C companies or 03, 04, or 18 for L/H companies).
5	Annual Statement Line Number	The line number on the page where the adjustment is reported (left justified, with a leading zero for numbers less than 10, that is, 02.2).
6	Annual Statement Column Number	The column number on the page where the adjustment is reported (1 for pages 03 and 04; 1, 2 or 3 for page 12 or page 18).
7	Amount	The amount field will be the year-end closing adjustment amount (positive for debit balance and negative for credit balance). The decimal point is to be contained in the field. A leading minus ("-"), placed directly before the first number, is used to indicate negative numbers. Leading zeros are not to be used, but trailing zeros are to be used for the decimal places. The total field width (16) includes all numbers, the minus sign and the decimal point. For example, a negative $304,020 and 20 cents would appear as _____-304020.20, where the underscore represents spaces.

LAW AND PUBLIC SAFETY

(a)

STATE BOARD OF DENTISTRY

Advertising

Reproposed Amendment: N.J.A.C. 13:30-8.6

Authorized By: State Board of Dentistry, Jerome Horowitz, D.D.S., President.
Authority: N.J.S.A. 45:6-3.
Proposal Number: PRN 1993-362.

Submit written comments by August 4, 1993 to:
Agnes Clark, Executive Director
State Board of Dentistry
124 Halsey Street, 6th Floor
Newark, New Jersey 07102

The agency proposal follows:

Summary

The Board of Dentistry is reproposing an amendment to N.J.A.C. 13:30-8.6 concerning professional advertising in order to change the existing regulatory standard for the use of testimonials. The original proposal published in the New Jersey Register on August 17, 1992 at 24 N.J.R. 2801(a) proposed a new subsection to permit both lay and expert testimonials so long as they are rendered within the stated parameters. The amendment also repeated the Board's requirement that any objective statement of fact appearing in a testimonial must be substantiated upon request by the Board. This new subsection replaces paragraph (c)5 which is proposed for deletion. In response to comments which were received during the official comment period and concerns raised by Board members during the course of discussion of adoption of the amendments to the advertising rule at a Board public meeting, it was expressed that a testimonial given by one who was paid compensation either directly or indirectly had the potential to be misleading and the fact of compensation should be disclosed to the public. Accordingly, this reproposal adds a requirement for a disclosure statement where compensation has been provided for the testimonial.

Social Impact

The reproposed amendment to N.J.A.C. 13:30-8.6 will provide licensees with a framework in which to more clearly and accurately advertise their services to the public. Testimonials in advertising may provide truthful statements about a dentist's services based upon personal knowledge or experience. Such first-hand expressions expand the availability of information in advertising and enable potential patients to evaluate choices among those offering dental services. The parameters for testimonials set forth in the rule, as well as the required disclaimer in instances where compensation is paid to the testimonial giver, are intended to curtail any potential abuses in this area which may tend to mislead the public.

Economic Impact

The reproposed amendment to N.J.A.C. 13:30-8.6 concerning the use of testimonials in professional advertising should have no general economic impact other than that which might be associated with competitive advertising.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., dentists are deemed "small businesses" within the meaning of the statute, the following statement is applicable.

The proposed amendment will apply to the approximately 9,000 licensed dentists in the State regardless of the size of the dental practice. The amendment does not involve reporting or recordkeeping requirements. Nor does it require a submission to the Board or the maintenance of a record which was not previously required. The amendment permits lay and expert testimonials within stated parameters. The amendment involves no capital costs or reporting requirements, and it is unlikely that any professional services will be needed to comply with the amendment.

The only potential cost will be that incurred by a licensee who may need to change a current advertising format in order to be in compliance with the rule. Such cost will not vary with the size of the business but may be proportionate to the scope and nature of the advertising. In view of the fact that the economic impact of the amendment, if any, is minimal, a design to further minimize any adverse economic impact on small businesses is not feasible. Similarly, no exemptions, whether for small or large practices, are possible since this would frustrate the intent of the rule.

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

13:30-8.6 Professional advertising

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

(c) A licensee who engages in the use of advertising which contains the following shall be deemed to be engaged in professional misconduct:

1.-4. (No change.)

[5. The use of any personal testimonial attesting to the technical quality or technical competence of a service or treatment offered by a licensee. Other testimonials shall be permitted so long as they are not violative of any other section of these regulations.]

Recodify existing 6.-9. as **5.-8.** (No change in text.)

(d)-(l) (No change.)

(m) An advertisement may contain either a lay or expert testimonial, provided that such testimonial is based upon personal knowledge or experience obtained from a provider relationship with the licensee or direct personal knowledge of the subject matter of the testimonial. A lay person's testimonial shall not attest to any technical matter beyond the testimonial giver's competence to comment upon. An expert testimonial shall be rendered only by an individual possessing specialized expertise sufficient to allow the rendering of a bona fide statement or opinion. An advertiser shall be able to substantiate any objective, verifiable statement of fact appearing in a testimonial, and the failure to do so, if required by the Board, may be deemed professional misconduct. Where an advertiser directly or indirectly provides compensation to a testimonial giver, the fact of such compensation shall be conspicuously disclosed in a legible and readable manner in any advertisement in the following language or its substantial equivalent:

COMPENSATION HAS BEEN PROVIDED FOR THIS TESTIMONIAL.

(a)

STATE BOARD OF MEDICAL EXAMINERS

Notice of Request for Informal Public Input Advertising and Solicitation Practices N.J.A.C. 13:35-6.10(m)

Authorized By: Board of Medical Examiners, Sanford Lewis, President.

Authority: N.J.S.A. 45:9-2.

Take notice that on February 10, 1993, the Board of Medical Examiners voted to charter a committee to study this regulatory provision, which provides that:

Any licensee advertising board certification in a specialty must possess certification by a certifying agency recognized by the Board of Medical Examiners. A list of recognized agencies shall be maintained by the Board.

The committee will determine whether any amendment to this provision is warranted. Specifically, the committee will report back to the Board as to whether this regulation is the most efficacious means of protecting the public against the advertising of specious certifications; whether and what specific standards and guidelines should be established; and whether the regulation as written should be more detailed. The committee is expected to provide the Board with recommendations within six months.

Take further notice that at the February 10 meeting the Board also voted to stay the effect of N.J.A.C. 13:35-6.10(m) pending receipt of the committee's report and the Board's action thereon.

Take further notice that the Board invites any interested persons to submit in writing any data, views or arguments relevant to the proposed review on or before September 1, 1993. These submissions, and any inquiries about submissions and responses, should be addressed to:

Charles A. Janousek, Executive Director
Board of Medical Examiners
28 West State Street
Trenton, New Jersey 08608

(b)

STATE BOARD OF MEDICAL EXAMINERS

Alternative Resolution Program Proposed New Rules: N.J.A.C. 13:35-11

Authorized By: State Board of Medical Examiners, Charles A. Janousek, Executive Director.

Authority: N.J.S.A. 45:9-2.

Proposal Number: PRN 1993-364.

Submit written comments by August 5, 1993, to:

Charles A. Janousek, Executive Director
State Board of Medical Examiners
28 West State Street
Trenton, New Jersey 08608

In addition, the Board will conduct a **public hearing** on Thursday, August 5, 1993 at 9:30 A.M. at the Office of Administrative Law, Room 1, Quakerbridge Plaza, Trenton, New Jersey. Persons wishing to speak at this hearing must submit a synopsis of the proposed statement to Mr. Janousek no later than July 26, 1993 so that the Board may determine the sequence and identity of speakers who will provide it with relevant, non-cumulative comments and data.

The agency proposal follows:

Summary

For several years the Board of Medical Examiners has been desirous of implementing a program to encourage physicians and other healthcare professionals under Board jurisdiction, who are suffering from chemical dependencies and other impairments, to disclose their status to a State entity. The Board has felt that, if Board licensees and their colleagues could be assured that reports would be handled confidentially and would not necessarily result in certain public forms of discipline, it would learn of more licensees suffering from impairments and thus it would be in a better position to restrict and monitor their practices.

More than four years ago, the State Commission of Investigation (SCI) issued a report on impaired and incompetent physicians. The SCI had, as a result of its investigation, concluded that a significant number (estimated at between three percent and 18 percent) of physicians practicing in New Jersey were impaired. In addition, the SCI was highly critical of the Impaired Physicians Program (IPP), a subsidiary of the Medical Society of New Jersey, and the informal relationship that the Board of Medical Examiners had with that program. Specifically, the SCI noted the Board's failure to take steps to try to learn the identities of the many physicians who were then voluntarily and confidentially participating in the program. The SCI also cited examples of instances where the IPP had failed to expeditiously report to the Board relapses by participants whom the Board had referred to the program, relying upon the program to monitor those persons and report any relapse. The SCI report included a series of recommendations, many of which concerned ways in which the Medical Board and other health care boards could more readily identify problem practitioners. Specifically included were recommendations for statutory provisions expanding the reporting mandates placed upon hospitals and insurers and creating a statutory obligation that required all health care professionals to report problem colleagues.

One year after the issuance of the report in October of 1988, Senator Richard Codey introduced legislation, focused solely on physicians and podiatrists, which incorporated many of the reforms which had been recommended by the SCI, including expanded hospital and insurer reporting. That legislation, P.L. 1989 c.300, enacted in January of 1990, also created a colleague reporting provision, which compels practitioners to report other practitioners demonstrating impairments or gross incompetence to the Board. Failure to do so can subject the practitioner with such knowledge to disciplinary action and civil penalties. In the three years that have passed since the enactment of this section the Board has received only a handful of colleague reports. This legislation also amended N.J.S.A. 26:2H-12.2, requiring health care facilities to promptly report privilege actions which have not risen to the level of a suspension by the governing body. The Board has seen a marked increase in the number of reports received from hospitals.

In the private sector, the Medical Society for many years now has operated a program, first denominated as the Impaired Physician's Program and now known as the Physician's Health Program (PHP), which has endeavored to assist physicians suffering from chemical dependencies and psychiatric problems in seeking help. The PHP reports that since its inception the program has had more than 700 participants in various stages of recovery. It is staffed by two physicians and a clergyman, who jointly provide support, monitoring and advocacy services. It is funded through Medical Society dues and monies received from the State's two major medical malpractice insurers. Upon receiving a report about a problem physician, the program will make a preliminary assessment and, if warranted, in the judgment of the director, schedule a confrontation. If the problem is acknowledged, the staff will arrange for treatment, lining up an in-patient rehabilitation stay or out-patient services. Upon discharge from an inpatient stay the treated physician is expected to enter into an aftercare contract with the program which spells out the monitoring regimen and schedule of support group meetings or therapy visits. At present, if the physician is cooperative and compliant, or if the PHP concludes that there is no problem, the Board may never be advised that the physician is a participant or was evaluated. With respect to those participants about whom the Board does have knowledge, the terms of the aftercare contract very often are incorporated in a consent order which may also place practice restrictions upon the doctor for a period of probation. At present the Board is receiving reports from the PHP on approximately 75 licensees. With respect to many others, for example, those who have remained chemically free for five years or more, the PHP has agreed to provide notice of any relapse which comes to its attention.

While the Board has relied, and continues to rely, on the PHP to provide it with reports concerning those licensees about whom it has knowledge, and is appreciative of the prompt and thorough responses it receives from the program director, the Board firmly believes that it should play a more active role in identifying and reviewing the monitoring of any Board licensee who have been recognized as having an impairment, including those who are PHP participants. The Board recognizes that there are distinct differences in the objectives and implementation resources available to the Board and to the PHP. The Board's first obligation is to assure that a rehabilitation plan is adequately protective of the public; the PHP's goal is to rehabilitate the problem doctor. Moreover, because of its investigatory authority and resources, the Board may have a better ability to assess the veracity of a licensee's story; by contrast the PHP must necessarily accept at face value what the licensee says. Although the Board would readily recognize other groups or programs which might offer it the same package of services (and could clearly do so under the statute and these proposed rules), it has had little experience to suggest that at present there are comparable programs which have sought to cultivate doctors as clients.

The Board continues to embrace the premise that physicians ought to be able to seek and receive help for problems relating to chemical dependency without public disclosure or traditional discipline—provided that the public is protected during the rehabilitation process. Thus the Board is proposing to establish a mechanism, or an alternate track, by which an impaired physician can secure treatment, agree to appropriate practice restrictions, and be monitored under a regime subject to the oversight of a sub-entity of a State agency, without the creation of a public disciplinary formal order. By these rules the Board would accord recognition to professional assistance programs, such as the PHP, conditioning approval (and confidentiality) on the program's agreement to adhere to Board imposed standards. (Failure to conform to these standards could result in a recision of the program's recognition.) The mechanism proposed herein contemplates that a subcommittee of the Panel (the Impairment Review Committee (IRC)) would review proposed rehabilitation plans, without learning of the participant's identity, but with full information concerning the nature of the practice and of the problem. In these proposed rules it is contemplated that the IRC will include two individuals who are to be appointed by the Board President, who are neither Board members, nor panel members, but are representatives of approved professional assistance programs. (If comments on this proposal made via testimony at the public hearing or in writing point up the need to reevaluate this configuration of the IRC—either from a policy perspective or in consideration of the practical difficulties which may be engendered should any member need to recuse him or herself based on personal knowledge of the participant—the Board is prepared to reassess the membership set forth herein.) The director of the professional assistance program is to disclose the identity of the practitioner to both the Executive Director of the Board and the Medical Director of the Board so that the IRC can be made aware of concurrent investigations or consumer complaints which present information in conflict with that being presented by the licensee. If needed, the IRC can request the appearance by the physician. Thereafter a letter-agreement would be fashioned embodying certain terms protective of the public, which would be submitted to the Board for review. Based on a coded narrative report, without utilizing information which identifies the impaired licensee, the Board would then approve the plan or direct that reconsideration be undertaken if it is unsatisfied with some of the elements of the agreement.

By creating a confidential program, colleagues of that licensee might be encouraged to report more promptly if they have a reasonable expectation that their reports will not result in discipline and public disclosure. Accordingly, by this proposal, the Board is giving notice to its licensees that it will consider a report to IRC utilizing a code number assigned by an approved professional assistance program to satisfy the colleague reporting requirement set forth at N.J.S.A. 45:9-19.5

Social Impact

The Board hopes that voluntary self-reports may become more common if licensees are informed that a non-disciplinary route may be available. The Board would retain the option of public pursuit of impairment cases which come to light from other sources (hospitals, insurance companies, patients, and law enforcement agencies); referral of even some of these cases to this alternative track may be desirable. The public should be aware, however, that there are two major disadvantages implicit in the alternate track model. First, the letter agreements are not independently enforceable. Allegations of violations would need to be presented to the Board for the initiation of the disciplinary process, not to Superior Court for enforcement of a final order. Second, and more importantly, the Board would be "trading off" the ability to provide the public with information about health care providers which some may feel to be important. In the traditional disciplinary format—if a prosecution is successful or a consent order is negotiated—restrictions and penalties, if any, would be memorialized in a document available to the public on request. Obviously, if the Board were to fashion a diversionary track that assured confidentiality to first time participants who sought help voluntarily or who were reported by colleagues, the public would be losing access to some information about its health care professionals to

which many would argue it is entitled. The Board, however, firmly believes that the public will be better served if physicians who have problems come forward voluntarily, before their problems may reach a point which could jeopardize their patients. Reasonable practice-monitoring regimes, fashioned with input from a State entity, should assure the public that these practitioners are practicing with requisite skill and safety. The Board expects that the benefits to be derived through the anticipated increase in reporting and the greater ability to monitor and oversee the rehabilitation process outweigh the public interest in identifying some impaired physicians.

Economic Impact

While it is difficult to quantify the economic impact of the proposed new rules, certainly the mechanisms being set up will entail administrative costs. Members who participate on the IRC will, of course, be reimbursed at the standard rate. Staff support is also necessary. Significantly, however, the Board believes that once this program is operational it may represent an ultimate savings since those who are compliant may never have to be directed into the disciplinary track, thus providing a savings in both investigation and prosecution costs.

More significantly, this program enables the Board to intervene in impairment problems in their incipient stages. It is designed to enable practitioners to get the help they need before their impairments have had negative impact on patients. Although it is often suggested that physician impairments are demonstrable in social spheres before professional performance is impacted, early intervention can serve to protect the public from both the monetary and human costs associated with ineffective or inappropriate care.

Programs which seek Board approval may experience increased costs in their effort to adhere to the standards set forth in the rules. Also it is hoped that as a result of creating this alternative to disciplinary handling, such programs may receive additional referrals. Of course licensees participating in a program may also have costs associated with their treatment and monitoring regimens. Practice restrictions may also have an economic impact. If problems are identified early however those costs may be far less than the costs which could be incurred if patient harm were to result from physician impairments.

Regulatory Flexibility Analysis

To the extent that the professional assistance programs may be considered small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., those choosing to seek approval from the Board will have to agree to provide the IRC with periodic reports on the monitoring results and rehabilitative progress of the participants who they sponsor. Such reports are deemed necessary to assure the Board and the public that the IRC and the programs are adequately overseeing the rehabilitation process and practice safeguards. Participating licensees, and sometimes their partners or employers, may also be required to provide periodic reports relating to practice performance and rehabilitative efforts. It is not known how many programs may ultimately seek approval, nor can the actual costs associated with the operation of a program in conformance with the standards as established by the Board be accurately calculated at this time.

Individual licensees who seek admission to the program are not small businesses, and thus the analysis mandated by the Regulatory Flexibility Act is not required.

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

SUBCHAPTER 11. [(RESERVED)] **ALTERNATIVE RESOLUTION PROGRAM**

13:35-11.1 Objectives of the Alternative Resolution Program

(a) By this subchapter, the Board of Medical Examiners is implementing a program, to be known as the Alternative Resolution Program, to encourage physicians at risk of developing, susceptible to, or suffering, from chemical dependencies and other impairments to disclose their status to an entity of state government which, in a confidential manner, can assure that practice restrictions are fashioned and rigorous monitoring undertaken. A participating licensee who is compliant with the terms of an agreed-upon rehabilitation regime thus will be provided with an avenue to avoid the initiation of a disciplinary proceeding. In addition, this subchapter sets forth the standards to which a professional assistance program must agree to adhere with respect to treatment and monitoring when seeking Board approval to sponsor licensees participating in the Alternate Resolution Program. Also the Board is establishing the criteria for notifying the Board when a licensee fails to comply with the requirements of the treatment program or when a licensee's impairment may jeopardize or unreasonably risk the health, safety or life of a patient. This subchapter also delineates a mechanism by which the Board may rescind its approval of a professional assistance program, upon a demonstration that the program has failed to adhere to the agreed upon standards or has proven to be otherwise unreliable.

13:35-11.2 Definitions

As used in this subchapter, the following terms have the following meanings unless the context indicates otherwise:

"Chemical dependency" means a condition involving the continued misuse of psychoactive substances including illicit and licit substances and/or alcohol which presents a significant risk that the chemically dependent individual's intellectual ability and/or physical capabilities to safely and responsibly discharge the functions of a licensee may be impaired. Chemically dependent individuals may be, but are not limited to, individuals who may present the diagnostic criteria set forth in the Diagnostic and Statistical Manual, Third Edition, Revised (DSM III(R)) definition of psychoactive substance dependency. These criteria include:

1. A psychoactive substance is often taken in larger amounts or over a longer period than the person intended;

2. Persistent desire for or one or more unsuccessful efforts to reduce the use of psychoactive substances;

3. A substantial amount of time is spent in activities necessary to obtain the psychoactive substance, taking the substance or recovering from its effects;

4. Frequent intoxication or withdrawal symptoms are present even when expected to perform patient care functions or the continued substance use is physically hazardous (for example, driving when intoxicated);

5. Important social, occupational, or recreational activities given up or reduced because of substance use;

6. Continued substance use despite knowledge that such use is causing or exacerbating persistent or recurrent social, psychological, or physical problems (for example, the individual keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking);

7. Marked tolerance evidenced by a need for increased amounts of the substance in order to achieve intoxication or desired effect or a diminished effect with continued use of the same amount;

8. Characteristic withdrawal symptoms, as appropriate to the particular psychoactive substance; or

9. The substance often taken to relieve or avoid withdrawal symptoms.

"Confidential" means that a participating licensee's identity (as well as any information from which a licensee's identity could be deduced) shall be maintained in a limited access file, with disclosure provided only to those persons whom the Board or the Panel or the IRC determine have a need to know, in order to perform their role in the review process.

"Impairment" means an inability to function at an acceptable level of competency, or an incapacity to continue to practice with the requisite skill, safety and judgment as a result of alcohol and/or chemical dependency, a psychiatric and/or emotional disorder, senility or a disabling physical disorder.

"Impairment Review Committee" or "IRC" means the subcommittee of the Medical Practitioner Review Panel created pursuant to this subchapter.

"Licensee" means a physician (including a resident or intern), podiatrist, bioanalytical laboratory director, certified nurse midwife, physician assistant or other professional subject to regulation by the Board.

"Panel" means the Medical Practitioner Review Panel.

"Professional assistance program" means a publicly or privately organized entity offering a constellation of services to facilitate the

rehabilitation of licensees suffering from chemical dependencies or other impairments. A program may limit its services to specific categories of licensees.

13:35-11.3 Criteria for approval of professional assistance programs

(a) The Board shall accept and review applications from professional assistance programs seeking approval to sponsor participants in the Alternative Resolution Program. All applications shall be made on such forms as the board may devise, which shall require sufficient information (that is, staffing, services provided, available treatment referrals and monitoring contracts) to assure that the applicant program is in a position to adhere to the standards set forth in this section. Each application shall designate a plenary licensed physician who shall serve as program director and who shall be responsible to assure that the program adheres to the standards and criteria set forth herein. Any professional assistance program seeking approval from the Board shall agree to perform the following duties, as well as such others as the Board may require. The program shall:

1. Establish a 24 hour State-wide hotline telephone number and shall accept reports concerning licensees who may be suffering from chemical dependencies or other impairments;

2. Receive referrals from the IRC;

3. Promptly conduct appropriate inquiry with regard to every referral received to determine whether the information indicating licensee impairment is sufficiently reliable to warrant further review, and may request of the IRC that further investigation be conducted by staff, investigative personnel or the Attorney General;

4. Make a summary report to the IRC concerning every referral which suggests that a licensee has a chemical dependency or other impairment. That report shall indicate the licensee's code number and sufficient information concerning the suspected impairment and the nature of the practice for the IRC to conduct a meaningful review. The report shall address:

i. The nature of the impairment;

ii. Whether the licensee rendered or attempted to render or was expected to render care at a time when impaired;

iii. Whether patients were harmed either directly or indirectly by the licensee's conduct;

iv. Whether the licensee has engaged in an activity which could render that licensee subject to criminal penalty including, but not limited to, the illegal distribution of controlled dangerous substances or sexual abuse of patients; and

v. Whether the licensee has undergone a rehabilitation program previously, and when.

5. Make a recommendation to the IRC concerning:

i. What treatment is warranted;

ii. What services will be provided by the sponsoring program;

iii. What practice restrictions should be imposed, if any;

iv. What monitoring regimen should be instituted, if any;

v. What supervision and reporting should be required and by whom; and

vi. At what frequency periodic reports to the IRC should be provided;

6. Recommend no further action when, after inquiry, there is insufficient information upon which to conclude that the licensee is suffering from a chemical dependency or other impairment;

7. Conduct such supplemental inquiry as may be directed by the IRC, the Panel or the Board;

8. Become co-signatories to the letter agreements with participating licensees embodying the terms of participation as approved by the Board. The agreements shall mandate that certain notice be provided to other jurisdictions if the licensee should elect to leave this State or should apply for initial licensure in another state, or in response to an inquiry from another state or regulatory agency or health care facility at which the licensee has applied for privileges;

9. Immediately notify the IRC of any rejection by the licensee of a term of participation;

10. Promptly prepare all reports required pursuant to such letter agreements and, as appropriate, coordinate the submission of any other documentation directed;

11. Immediately report to the IRC and disclose the identity of the participating licensee if that licensee:

i. Has not complied with the terms of the letter agreement;

ii. Has been the subject of a urine or blood test report which is positive for the presence of a substance not appropriately prescribed for a legitimate documented reason;

iii. Has otherwise demonstrated a relapse or impairment;

iv. Has engaged in deceptive behavior (that is, an attempt to invalidate a drug screen, substitute a specimen, present a fraudulent attendance record;

v. Has suffered an exacerbation of a condition rendering the licensee incapable of practicing with requisite skill and safety; or

vi. Has had his or her status changed (that is, has been the subject of a disciplinary proceeding at a health care facility, has been arrested or has disappeared);

12. Obtain from all participating licensees consent to provide all pertinent medical, psychiatric or personnel reords to the IRC upon request, as well as the licensee's consent to provide the letter agreements and updates to any other state or jurisdiction in which he or she may be currently licensed or may seek licensure; and

13. Throughout the duration of the term of the agreement, maintain the agreement and information relating to the licensee in a confidential manner, except that nothing herein shall preclude the Board, the Panel, the IRC or the Attorney General from requiring the production of such information as part of an independent investigation.

13:35-11.4 Notification of Board personnel

The program director shall provide the Executive Director and the Medical Director of the Board with the identity of each individual for whom a summary report is made, which identity shall be retained confidentially. The Executive Director shall assure that there is no information concerning concurrent investigations or consumer complaints. With regard to independent referrals (not made by an approved professional assistance program), the Executive Director shall provide the IRC with all of the information, including the identity of the individual, which was provided with the referral, along with any information concerning concurrent investigations or consumer complaints. With respect to those referrals made by approved professional assistance programs, the Executive Director shall also advise the IRC of any information concerning concurrent investigations or consumer complaints, without disclosing the identity of the licensee, so that the IRC will be in a position to assess whether participation in the program is appropriate.

13:35-11.5 Creation of Impairment Review Committee

The Board shall authorize a committee of the Panel to review matters involving practitioners suffering from chemical dependencies or other impairments. This committee shall be comprised of five members to include: a physician member of the Panel experienced in the field of chemical dependency and a consumer member of the Panel and the Panel member who is also a Board member serving *ex officio*. In addition, the Board President shall appoint two individuals representing an approved professional assistance program, one of whom shall be the program director of an approved program. In the event that any of the panel members are unavailable and there is a need for member recusal, the Chairman of the Panel or a designee may serve as a replacement. This committee shall be known as the Impairment Review Committee ("IRC") and shall meet on an as needed basis. The Medical Director of the Board and the Executive Director of the Board shall assist the committee in its work.

13:35-11.6 Duties of the Impairment Review Committee

(a) The IRC shall perform the following duties, as well as such others as the Board may require. The IRC:

1. Shall accept from licensees, and from other members of the public, reports (with the individual's identity) concerning licensees

who may be suffering from chemical dependencies or other impairments;

2. Shall receive referrals (with the individual's identity) from the Board;

3. May request that further investigation be conducted by staff, investigative personnel or the Attorney General;

4. May request the confidential appearance of any licensee or other person who is believed to have knowledge concerning the referral;

5. May request that relevant materials, with identifying information redacted, be referred to a consultant(s) for the preparation of a confidential independent report;

6. May request the production of relevant records or documents, including the licensee's medical or psychiatric records and laboratory test reports relating to the referral;

7. Shall promptly review and consider each referral and upon completion of that review or within 60 days, whichever occurs first, make a summary report to the Panel. The report shall be incorporated in the summary report which the Panel shall make to the Board. If the IRC review has been initiated by a self-referral or by a report by another practitioner, reports shall be made without the disclosure of the licensee's name or other identifying information. If the IRC has concluded that, based upon its review, there is insufficient information upon which to conclude that the licensee is suffering from a chemical dependency or other impairment, it shall so state in its confidential summary report, indicating the extent of its review;

8. Shall give consideration to the following factors in formulating its recommendation as to participation:

i. The nature of the impairment;

ii. Whether the licensee rendered or attempted to render or was expected to render care at a time when impaired;

iii. Whether patients were harmed either directly or indirectly by the licensee's conduct;

iv. Whether the licensee has engaged in an activity which could render the licensee subject to criminal penalty, including, but not limited to the illegal distribution of controlled dangerous substances or sexual abuse of patients;

v. Whether the licensee has undergone a rehabilitation program previously, and when; and

vi. Whether such factors in a particular case would make participation in the Alternate Resolution Program inconsistent with the public interest;

9. Shall address in its confidential summary reports, with respect to those licensees for whom it is recommending that participation be permitted, the following, as appropriate:

i. What treatment is warranted;

ii. What services will be provided by the sponsoring program;

iii. What practice restrictions should be imposed, if any;

iv. What monitoring regimen should be instituted, if any;

v. What supervision and reporting should be required and by whom; and

vi. At what frequency periodic interviews with the IRC should be scheduled;

10. Shall conduct such supplemental inquiry as may be directed by the Board;

11. Shall enter into letter agreements with participating licensees embodying the terms of participation as approved by the Board and mandating that certain notice shall be provided to other jurisdictions if the licensee should elect to leave this State or should apply for initial licensure in another state, or in response to a particular inquiry from another state or regulatory agency or a health care facility at which the participating licensee has applied for privileges;

12. Shall notify the Panel and in turn the Board of any rejection by the licensee of a term of participation, and if no new agreement can be reached, shall notify the licensee that he or she may not participate in the program and shall disclose the licensee's identity and transmit the entire IRC file to the Board for appropriate disciplinary review;

13. Shall promptly review all reports submitted pursuant to such letter agreements, requesting supplemental investigation or appearances, as appropriate;

14. Shall immediately review any report indicating that a participating licensee has not complied with the terms of the letter agreement or has otherwise demonstrated a relapse or impairment, and shall thereafter provide the Board with notice of any information, which appears to be reliable and for which no acceptable explanation has been proffered, concerning noncompliance;

15. Shall provide the Board with periodic reports, on at least a quarterly basis, as to the status of participating licensees and any recommendations for modification of the terms of agreement;

16. Shall obtain from all participating licensees consent to review all pertinent medical, psychiatric or other therapy records, and personnel records, as well as the licensee's consent to provide the letter agreements and updates to any other state or jurisdiction in which he or she may be currently licensed or may seek licensure or in response to particular inquiry from another state or regulatory agency or health care facility at which the participating licensee has applied for privileges;

17. Shall, throughout the duration of the term of the agreement, maintain the agreement and information relating to the licensee as a matter under investigation relating to possible licensee misconduct and thus shall, except as provided herein, afford confidentiality pursuant to N.J.S.A. 45:9-19.2, except that nothing herein shall preclude the Board, the Panel, the IRC or the Attorney General from conducting appropriate investigation of the relevant facts, securing opinions from consultants and complying with judicial directives; and

18. Shall, upon a licensee's successful completion of the terms as provided by the letter agreement, advise the Board that it deems the matter to be closed without a finding of cause for action, except that nothing herein shall preclude the Board or the Panel from reviewing and relying upon all relevant materials should it receive a subsequent referral regarding the licensee.

13:35-11.7 Professional assistance program approval

Upon reviewing an application submitted by a professional assistance program seeking approval, the Board shall determine whether the program demonstrates that it is willing and able to comply with the standards set forth in this subchapter and, if so, the Board shall grant its approval. In its next subsequent newsletter, the Board shall advise licensees of the availability of the program. The Board shall also provide notice to all health care facilities licensed by the Department of Health. The approved professional assistance program is encouraged to engage in such educational activities as it may deem appropriate to assure that members of the professional community are made aware of its services.

13:35-11.8 Professional assistance program approval rescission

Should the Board be made aware of any information indicating that an approved professional assistance program has failed to provide a timely report, or a report in a manner required by the standards to which it has agreed, or has misrepresented any material fact or has omitted a material fact, the program shall be notified and given 10 days within which to provide the Board with an explanation. If the Board is not satisfied with the explanation offered, it may direct such measures as it may deem appropriate to remedy the lapse. If the Board subsequently is made aware of a second omission or misrepresentation, it may rescind its approval of the program after notice and opportunity to be heard. Upon recission of its approval, the Board shall notify all health care facilities licensed by the Department of Health and shall provide notice of the recission in the next newsletter. In addition, the Board shall direct the IRC to notify participating licensees for whom the professional assistance program had been serving as a sponsor.

13:35-11.9 Colleague referrals

The Board authorizes the IRC to accept reports from practitioners pursuant to N.J.S.A. 45:9-19.5 and any practitioner who files such a report directly with the IRC or with any of the report recipients otherwise authorized by law shall be deemed to have discharged the obligation imposed by statute. Any practitioner reporting a licensee

who is a participant in the ARP or who has been referred to an approved professional assistance program may utilize that licensee's code number in the report. These reports shall be retained confidentially if the licensee agrees to the terms of participation in the program.

13:35-11.10 Alternate Resolution Program pilot period

Two years following the operative date of this subchapter, the Board shall determine, after study and consultation, whether the program established pursuant to this subchapter should be continued, altered, expanded or discontinued. Should the Board conclude that the program should be terminated, those currently participating shall be permitted to continue with the confidentiality protection set forth in this subchapter. Should the Board determine to rescind the approval previously granted to a particular professional assistance program, it shall allow participating licensees a period of 30 days to seek the sponsorship of another approved professional assistance program provided that interim monitoring provisions are proposed and acceptable to the Board.

(a)

STATE BOARD OF NURSING

Certification of Nurse Practitioners/Clinical Nurse Specialists

Proposed New Rules: N.J.A.C. 13:37-7

Authorized By: State Board of Nursing, Sister Teresa L. Harris, Executive Director.

Authority: N.J.S.A. 45:11-24 and 45:11-46 to 50.

Proposal Number: PRN 1993-365.

Submit written comments by August 4, 1993 to:

Sister Teresa Harris, Executive Director
State Board of Nursing
124 Halsey Street, Sixth Floor
Newark, New Jersey 07102

The agency proposal follows:

Summary

The New Jersey Board of Nursing is proposing to establish regulations for the certification and prescriptive practice of nurse practitioners and clinical nurse specialists. The proposed new rules will establish the educational and licensing qualifications for practice as a nurse practitioner and clinical nurse specialist in the State of New Jersey.

N.J.A.C. 13:37-7.1 sets forth the procedural requirements for submitting an application to practice as a nurse practitioner/clinical nurse specialist. Each nurse who seeks to present, call or represent himself or herself as a nurse practitioner/clinical nurse specialist must be certified by the Board. This section requires each applicant for certification to submit documentation to the Board demonstrating: (a) proof of a current New Jersey license as a registered professional nurse; (b) a completed application form and the application fee; and (c) proof that the applicant has successfully completed the educational requirements. The applicant is required to obtain verification from the school(s) where the applicant completed the educational requirements and proof that the applicant has successfully completed the certification examination requirements.

N.J.A.C. 13:37-7.2 sets forth the educational requirements for certification. This section requires each applicant for certification to successfully complete and graduate from an accredited masters level program. This section also requires each applicant to successfully complete an accredited graduate credit course in pharmacology or an equivalent integrated pharmacology course approved by the Board. This section requires that each applicant who has completed the pharmacology requirements more than five years prior to filing an application must successfully complete either an accredited graduate credit course in pharmacology or 30 contact hours in approved continuing professional education courses devoted to pharmacology and patient care management. A minimum of 10 contact hours must be in the area of pharmacology. A minimum of 20 contact hours must be in patient care management in the area of specialty.

N.J.A.C. 13:37-7.3 sets forth the examination requirements for certification. This section requires each applicant for certification to successfully pass a written advanced practice examination in the area of his or her specialization approved by the Board. This section permits each applicant who meets the educational requirements of N.J.A.C. 13:37-7.2 and applies to take the first available examination for which the applicant is eligible may engage in advanced nursing practice pending the results of the first available examination, provided that they do not assume the title or designation of a "nurse practitioner/clinical nurse specialist" or any of its abbreviations.

N.J.A.C. 13:37-7.4 states that a waiver of the educational and examination requirements of N.J.A.C. 13:37-7.2 and 7.3 will be given to applicants seeking certification as a nurse practitioner/clinical nurse specialist in the specialty area of OB/GYN or women's health on or before December 31, 2001 or eight years from the effective date of these rules, whichever is longer. Each applicant is required to submit proof of successful completion of a post basic nursing certificate program accredited and/or approved by an entity acceptable to the Board of at least one academic year in the area of OB/GYN or Women's Health; proof of current certification from a nationally recognized OB/GYN or women's health certifying body approved by the Board; proof of successful completion of a six month preceptor program approved or given by an entity acceptable to the Board; and proof of successful completion of a pharmacology course integrated into the curriculum of his or her post basic nursing certificate program. This section requires that each applicant who has completed the pharmacology requirements more than five years prior to the filing date of the initial application must successfully complete either an equivalent pharmacology course as determined by the Board or 30 contact hours in approved continuing professional education courses devoted to pharmacology and patient care management. A minimum of 10 contact hours must be in the area of pharmacology. A minimum of 20 contact hours must be in patient care management in the area of specialty.

N.J.A.C. 13:37-7.5 sets forth the biennial certification renewal requirements. This section states that an applicant for certification renewal must submit proof that during the two calendar years immediately preceding application for renewal the applicant successfully completed 30 contact hours in approved continuing professional education courses devoted to specialty practice and pharmacology. A minimum of 10 contact hours must be in the area of pharmacology. A minimum of 20 contact hours must be in the area of patient care management.

N.J.A.C. 13:37-7.6 states that each nurse practitioner/clinical nurse specialist is required to prescribe or order medications/devices in conformity with the provisions of this rule and jointly developed protocols. The section also requires that these joint protocols must be reviewed, updated and signed at least annually by the nurse practitioner/clinical nurse specialist and a collaborating physician.

N.J.A.C. 13:37-7.7 establishes the requirements for nurse practitioners/clinical nurse specialists who issue prescriptions and orders, and dispense medications. This section states that every nurse practitioner/clinical nurse specialist must prepare all prescriptions and orders, and dispense medications in accordance with accepted standards of practice. Certain basic identifying information must be printed on all prescriptions and orders including: the prescriber's full name, certification number and academic degree; the patient's full name, age and address; the date of issuance of prescription/order; the signature of prescriber, hand-written; and the collaborating physician's full name and academic degree. This section also requires every nurse practitioner/clinical nurse specialist who prescribes/orders medications to provide certain basic information on all prescriptions, including: the name, strength, route and quantity of drug or drugs to be dispensed; adequate instructions for the patient; and the number of refills permitted or time limit for refills. This section requires that every prescription blank must be imprinted with the words "substitution permissible" and "do not substitute" and contain space for the nurse practitioner/clinical nurse specialist's initials next to the chosen option. This section requires every nurse practitioner/clinical nurse specialist to assure that each container of medication dispensed directly to a patient is labeled in a legible manner with certain basic information, including: the nurse practitioner/clinical nurse specialist's and the collaborating physician's full names; the patient's full name; the date the medication is dispensed; the expiration date of medication; the name, strength and quantity of medication dispensed; and adequate instructions for the patient regarding the frequency of administration of the medication. Finally, this section requires that each container of medication dispensed shall contain only one type of medication and that no nurse practitioner/clinical nurse specialist is permitted to dispense drugs without complying with the standards set forth in this rule.

N.J.A.C. 13:37-7.8 sets forth the requirements for obtaining certification by endorsement. This section permits a nurse practitioner/clinical nurse specialist to be certified if, at the time of application, the applicant is certified in another state with substantially equivalent standards to the requirements in New Jersey.

N.J.A.C. 13:37-7.9 establishes the requirements for nurse practitioner/clinical nurse specialists certified pursuant to the grandfathering provision of N.J.S.A. 45:11-48. This section states that each applicant for certification under the grandfather clause must submit to the Board documentation to show: a) proof of a current New Jersey license as a registered professional nurse; b) a completed application form and application fee; and c) proof of certification as a nurse practitioner/clinical nurse specialist or advanced practice nurse in one or more of the specialization areas by a national accrediting organization which required its certificate-holders to successfully complete a nurse practitioner/clinical nurse specialist or advanced practice nurse program (including pharmacology) in its required currriculum, and successfully complete a written examination (including pharmacology). This subsection requires each applicant awarded certification under the grandfather clause to meet the pharmacology requirements of N.J.A.C. 13:37-7.2(c) and the biennial certification renewal requirements of N.J.A.C. 13:37-7.5.

N.J.A.C. 13:37-7.10 provides that the act and the rules will not be construed to limit, preclude or interfere with the practice of nursing as defined in N.J.S.A. 45:11-23 by duly licensed registered professional nurses as long as their duties are consistent with the accepted standards of nursing and they do not represent as a nurse practitioner/clinical nurse specialist.

N.J.A.C. 13:37-7.11 lists the categories of advanced practice recognized by the Board.

N.J.A.C. 13:37-7.12 states that each nurse practitioner/clinical nurse specialist is required to self-report: the use of alcohol or drugs which has or does adversely impair nursing practice; a current indictment and/or conviction of crime involving moral turpitude and/or a crime relating adversely to his/her practice; being a named defendant or respondent in a civil, criminal or administrative complaint; and voluntary license surrender or disciplinary action by any state or Federal board.

Social Impact

The proposed new rules will greatly benefit New Jersey's health care consumers. The proposed new rules will afford the public with increased access to a safe, effective health care alternative and will promote consumer protection through the certification process. The certification process provides for the identification of essential practice qualifications and inquiry into whether an individual nurse meets those qualifications on an on-going basis. The certification process also provides an unbiased forum for resolving complaints about the safety and competence of an individual practitioner.

The practice of the nurse practitioner/clinical specialist requires a high degree of specialized knowledge, skill, proficiency and independent decision-making. State regulation of these practitioners will help eliminate some potential health and safety risks to the public who receive these health care services. The certification process will assure that the complex activities performed by nurse practitioner/clinical specialists, including prescribing and ordering medications, laboratory and other diagnostic tests are regulated. The proposed new rules will provide the public with assurances of minimum competency and safety through the imposition of consistent titling, uniform standards and legal accountability. The proposed new rules will also serve to protect the public from unqualified practitioners.

Individual nurse practitioner/clinical nurse specialists will also benefit from the proposed new rules. For the first time in New Jersey, these practitioners will have clear authority for their practice and recognition of their skill, knowledge and proficiency in managing patient care in their particular area of expertise. The certification process will validate that nurse practitioner/clinical nurse specialists have met the essential qualifications for advanced practice, including prescribing and ordering medications/devices. Finally, the certification process will enable nurse practitioner/clinical nurse specialists to receive regular direct reimbursement for the services they perform.

Establishing minimal educational requirements for certification as a nurse practitioner/clinical nurse specialist may create the possibility that some capable individuals who have not completed the requisite graduate education course including pharmacology, may be excluded from prescriptive practice and using the title—nurse practitioner/clinical nurse specialist. For this reason, the proposed new rules recognize a grandfather clause which will provide for a reasonable time frame (six months) to phase in all active practitioners. The proposed new rule will also ensure that the registered professional nurse who is duly licensed in this State may continue to practice, consistent with accepted standards of nursing, and provided only that they do not represent as a nurse practitioner/clinical nurse specialist. The Board's rule will ensure that no registered professional nurse who is practicing in accordance with accepted standards of nursing will be excluded from practice but it will protect the use of the title, nurse practitioner/clinical nurse specialist and ensure that only certified nurse practitioner/clinical nurse specialists engage in prescriptive practice.

Economic Impact

The economic expenses for obtaining and maintaining certification as a nurse practitioner/clinical nurse specialist will be borne by the individual nurse. These expenses include administrative costs (for example, application and biennial renewal fees) as well as the costs of education and examination. The applicant will bear the cost of successful completion of a graduate-level program including pharmacology; and the cost of successfully passing an advanced practice examination. The applicant will bear the cost of paying the application fee, while the certificate-holder will bear the cost of paying biennial renewal fees and continuing education expenses. All of these costs are incurred on a voluntary basis by registered professional nurses who choose to practice as nurse practitioner/clinical nurse specialists. Since a nurse practitioner/clinical nurse specialist may expect higher remuneration for the services performed at an increased level of knowledge, skill and responsibility, the addiitonal costs are justified. The administrative, education and examination expenses accruing to the individual nurse are outweighed by the value of the service and the potential risks in not regulating this activity. These costs are necessary in order to maintain high standards in the profession and to protect the public health, safety and welfare. Other costs associated with certification will be borne by the Board of Nursing. For example, the Board of Nursing will be responsible for administrative (for example, personnel, equipment) expenses in connection with the implementation of the on-going certification process. Application and biennial renewal fees will be used towards meeting these costs.

The proposed rules will have a favorable economic impact upon the public. The Board estimates that approximately 250 registered professional nurses will seek certification. A consumer who chooses to be treated by a certified nurse practitioner/clinical nurse specialist may avoid the expense of seeing a licensed physician and thereby incur substantial economic savings. To the extent that consumers do choose to be treated by certified nurse practitioner/clinical nurse specialists, the practice of medicine may be economically affected. However, the economic impact upon the practice of medicine is greatly outweighed by the public benefits in providing consumers with a safe and effective means of broadening access to basic health care services.

Regulatory Flexibility Analysis

The Board estimates that approximately 250 of its approximately 80,000 current registered professional nurse licensees will seek certification to practice as a nurse practitioner/clinical specialist. Compliance requirements under the proposed rules are no more than those required by prudent professional practice. Certified nurse practitioner/clinical specialists must maintain records and report to the Board on the completion of 30 continuing education credits during each biennial period. Certified nurse practitioner/clinical specialists also must prescribe medications pursuant to jointly developed written protocols which must be reviewed, updated and signed at least annually by the nurse practitioner/clinical specialist and his or her collaborating physician. Finally, certified nurse practitioner/clinical specialists must prepare written prescriptions and orders, and dispense medications in accordance with accepted standards of practice which must include certain basic identifying information. Costs of compliance are as stated in the economic impact statement. No professional services are likely to be needed in order to comply.

Because the proposed rules seek to promote and protect the public health, safety, and welfare, they must be uniformly and consistently applied. Therefore, no differential treatment can be accorded to small businesses.

Full text of the proposed new rules follows:

SUBCHAPTER 7: CERTIFICATION OF NURSE PRACTITIONERS/CLINICAL NURSE SPECIALISTS

13:37-7.1 Application for certification

(a) Any nurse who wishes to practice as a nurse practitioner/clinical nurse specialist, or present, call or represent himself or herself as a nurse practitioner/clinical nurse specialist must be certified by the Board.

(b) Each applicant for certification shall submit the following materials to the Board:

1. Proof of a current New Jersey registered professional nurse license in good standing;

2. A completed application form and the application fee set forth in N.J.A.C. 13:37-12.1. The application form solicits information including: general biographical, educational and experiential data;

3. Proof that the applicant has successfully completed the educational requirements set forth in N.J.A.C. 13:37-7.2 or, where applicable, N.J.A.C. 13:37-7.4. The applicant shall obtain verification of successful completion from the school(s) where the applicant completed the educational requirements; and

4. Proof that the applicant has successfully completed the examination requirements set forth in N.J.A.C. 13:37-7.3 or, where applicable, the certification requirements of N.J.A.C. 13:37-7.4.

13:37-7.2 Educational requirements for certification

(a) Each applicant for certification shall be required to successfully complete and graduate from a masters level program designed to educate and prepare the nurse practitioners/clinical nurse specialists at a school duly accredited by the Council of Baccalaureate and Higher Degree Programs of the National League for Nursing and approved by the New Jersey Department of Higher Education or such other approving entity with equivalent educational standards acceptable to the Board.

(b) Each applicant shall be required to successfully complete a graduate credit course in pharmacology from a school duly accredited by the National League for Nursing or the American Council on Pharmaceutical Education or approved by the New Jersey Department of Higher Education. Successful completion of a pharmacology course integrated into the masters level program referred to in (a) above will satisfy this requirement. Said course shall have been successfully completed within five years prior to the filing date of the initial application for certification.

(c) Each applicant who has completed the pharmacology requirements referred to in (b) above more than five years prior to the filing date of his or her initial application for certification under N.J.S.A. 45:11-45 et seq. and this subchapter, shall be required to successfully complete one of the following:

1. A graduate credit course in pharmacology from a school duly accredited by the National League for Nursing or the American Council on Pharmaceutical Education or approved by the New Jersey Department of Higher Education or such other approving entity with equivalent educational standards acceptable to the Board; or

2. Thirty contact hours in continuing professional education courses devoted to pharmacology and patient care management and approved for credit by the New Jersey Department of Higher Education, the National League for Nursing, American Nurses' Association, New Jersey Nurses' Association or the American Council on Pharmaceutical Education or such other approving entity with equivalent educational standards acceptable to the Board. Ten of the 30 contact hours shall be in the area of pharmacology. The remaining 20 contact hours shall be in the specialty area of patient care management. Each contact hour shall represent or be equivalent to 50 minutes of actual course attendance.

13:37-7.3 Examination requirements for certification

(a) Each applicant for certification shall be required to successfully pass a written advanced practice examination in the area of specialization approved by the Board.

(b) Each applicant who meets the educational requirements of N.J.A.C. 13:37-7.2 and applies to take the first available examination for which the applicant is eligible may engage in advanced nursing practice pending the results of the first available examination, provided that the applicant does not assume the title or designation of a "nurse practitioner/clinical nurse specialist" or any of its abbreviations.

13:37-7.4 Educational and examination certification requirements in the area of OB/GYN and women's health

(a) Applicants seeking certification as a nurse practitioner/clinical nurse specialist in the specialty area of OB/GYN or women's health on or before December 31, 2001 or eight years from the effective date of these rules (whichever is longer) may be certified, provided said applicant submits the following to the Board:

1. Proof of successful completion of a post basic nursing certificate program accredited and/or approved by an entity acceptable to the Board of at least one academic year in the area of OB/GYN or women's health;

2. Proof of current certification from a nationally recognized OB/GYN or women's health certifying body approved by the Board;

3. Proof of successful completion of a six month preceptor program approved or given by an entity acceptable to the Board; and

4. Proof of successful completion of a pharmacology course which meets the following requirements:

i. A pharmacology course integrated into the post basic certificate program referred to in (a)2 above completed within five years prior to the filing date of the initial application for certification;

ii. An equivalent pharmacology course, as determined by the Board, completed within five years prior to the filing date of the initial application for certification; or

iii. Thirty contact hours of continuing professional education courses devoted to pharmacology and drug management approved for credit by the New Jersey Department of Higher Education, the National League for Nursing, American Nurses' Association, New Jersey Nurses' Association or the American Council on Pharmaceutical Education or such other approving entity with equivalent educational standards acceptable to the Board. Ten of the 30 contact hours shall be in the area of pharmacology. The remaining 20 contact hours shall be in the OB/GYN or women's health area of patient care management. Each contact hour shall represent or be equivalent to 50 minutes of actual course attendance.

13:37-7.5 Biennial certification renewal

(a) Every person who has been granted initial certification under N.J.S.A. 45:11-47 and 48 and this subchapter shall submit a timely application for certification renewal on a biennial basis. Subject to the grounds for disciplinary action listed in N.J.S.A. 45:1-21 or elsewhere in N.J.S.A. 45:11-23 et seq. or 45:1-14 et seq., a biennial certificate shall be issued by the Board upon the applicant's submission of proof that during the two calendar years immediately preceding application for renewal the applicant successfully completed 30 contact hours in continuing professional education courses devoted to specialty practice and pharmacology. Said courses shall be approved for credit by the New Jersey Department of Higher Education, the American Nurses' Association, the National League for Nursing, the New Jersey Nurses' Association, the American Council of Pharmaceutical Education or such other approving entity with equivalent educational standards acceptable to the Board. A minimum of 10 contact hours of such continuing professional education shall be in the area of pharmacology. The remaining 20 contact hours shall be in the specialty area of patient care management. Each contact hour shall represent or be equivalent to 50 minutes of actual course attendance. Failure to submit the aforementioned proof of continuing education shall constitute grounds for the refusal to renew said certification.

(b) No person shall practice as a nurse practitioner/clinical nurse specialist, or present, call or represent himself or herself as a nurse practitioner/clinical nurse specialist unless he or she has been duly issued and received a current biennial certificate to practice as a nurse practitioner/clinical nurse specialist pursuant to N.J.S.A. 45:11-45 et seq.

13:37-7.6 Prescriptive practice

Each nurse practitioner/clinical nurse specialist shall prescribe/order medications and devices in conformity with the provisions of

this subchapter, N.J.S.A. 45:11-45 et seq., (especially N.J.S.A. 45:11-49) and jointly developed protocols. Each nurse practitioner/clinical nurse specialist shall prescribe/order medications and devices only at location(s) where written joint protocols are reviewed, updated and signed at least annually by the nurse practitioner/clinical nurse specialist and his or her collaborating physician.

13:37-7.7 Requirements for issuing prescriptions and orders; dispensing medications

(a) Every nurse practitioner/clinical nurse specialist shall provide the following on all prescriptions and orders:

1. The prescriber's full name, address, telephone number, license number, certification number and academic degree. This information shall be printed on all prescriptions/orders;

2. The full name, age and address of the patient. For orders only, this information may be contained in a conspicuous location in the patient chart;

3. The date of issuance of prescription/order;

4. The signature of prescriber, hand-written; and

5. The full name and academic degree of the collaborating physician. For prescriptions only, the address and telephone number of the collaborating physician shall be printed.

(b) Every nurse practitioner/clinical nurse specialist who prescribes/orders medications shall, in addition to the information set forth in (a) above, provide the following on all prescriptions.

1. The name, strength, route and quantity of drug or drugs to be dispensed;

2. Adequate instructions for the patient; a direction of "prn" or "as directed" alone shall be deemed an insufficient direction;

3. The number of refills permitted or time limit for refills, or both;

4. Every prescription blank shall be imprinted with the words "substitution permissible" and "do not substitute" and shall contain space for the nurse practitioner/clinical nurse specialist's initials next to the chosen option, in addition to the space required for the signature in (a)4 above;

5. Every nurse practitioner/clinical nurse specialist shall assure that each container of medication dispensed directly to a patient is labeled in a legible manner with at least the following information:

i. The full name(s) of the nurse practitioner/clinical specialist and the collaborating physician;

ii. The full name of patient;

iii. The date medication is dispensed;

iv. The expiration date of medication;

v. The name, strength and quantity of medication dispensed; and

vi. Adequate instructions for the patient regarding the frequency of administration of the medication;

6. When a nurse practitioner/clinical nurse specialist dispenses a pharmaceutical sample which has been packaged and labeled by the manufacturer and such sample package contains the information required by (b)5ii, v and vi above, the information listed in (b)5i and iii, inclusive, above need not be added;

7. When a nurse practitioner/clinical nurse specialist dispenses a medication other than a sample exempted pursuant to (b)6 above in a container without sufficient space for the information required by this subsection, the container shall be placed in a large container or envelope and the larger container or envelope shall be labeled as indicated in this subsection; and

8. Each container of medication dispensed shall contain only one type of medication.

(c) In no instance shall a nurse practitioner/clinical nurse specialist dispense drugs or sign a blank prescription form without complying with the standards in (b) above.

13:37-7.8 Certification by endorsement

A nurse practitioner/clinical nurse specialist certified in another state who wishes to practice as a nurse practitioner/clinical nurse specialist, or present, call or represent himself or herself as a nurse practitioner/clinical nurse specialist must be certified by the Board and must meet all of the requirements provided in N.J.A.C. 13:37-7.1. The Board may, in lieu of the examination requirements of N.J.A.C. 13:37-7.1(b)4, accept proof that an applicant holds a current certification in a state whose standards at the time of application are substantially equivalent to those of this State.

13:37-7.9 Requirements for nurse practitioner/clinical nurse specialists certified pursuant to N.J.S.A. 45:11-48

(a) Until 180 days after the effective date of this subchapter, an individual who submits the following may qualify for certification without completing the educational and examination requirements set forth in N.J.A.C. 13:37-7.2 and 7.3:

1. Proof of a current New Jersey license as a registered professional nurse in good standing;

2. A completed application form and the application fee set forth in N.J.A.C. 13:37-12.1. The application form solicits information including: biographical, educational and experiential data; and

3. Proof that the applicant has been certified as a nurse practitioner/clinical nurse specialist or advanced practice nurse in one or more of the specialization areas listed in N.J.A.C. 13:37-7.8 by a national accrediting organization approved by the Board and that said national accrediting organization certifies that all persons awarded certification by said national accrediting organization met the following requirements:

i. Successful completion of a nurse practitioner/clinical nurse specialist or advanced practice nurse program which included pharmacology in its required curriculum;

ii. Successful completion of a written examination which included pharmacology.

(b) Each applicant awarded certification under N.J.S.A. 45:11-48 shall be required to meet the pharmacology requirements of N.J.A.C. 13:37-7.2(c) and the biennial certification renewal requirements of N.J.A.C. 13:37-7.4.

13:37-7.10 Practice as registered professional nurse

Nothing in N.J.S.A. 45:11-45 et seq. or this subchapter shall be construed to limit, preclude or otherwise interfere with the practice of nursing as defined by N.J.S.A. 45:11-23 by persons duly licensed as a registered professional nurse in this State, provided that such duties are consistent with the accepted standards of nursing and said registered professional nurse is not represented as a nurse practitioner/clinical nurse specialist.

13:37-7.11 Categories of advanced practice

(a) The following categories of nurse practitioners may be certified in accordance with the provisions of N.J.S.A. 45:11-45 et seq. and this subchapter:

1. Adult Health;
2. Family;
3. Pediatric;
4. School;
5. Gerontological;
6. Women's Health;
7. OB/GYN;
8. Neonatal; and
9. Psychiatric/Mental Health.

(b) The following categories of clinical nurse specialists may be certified in accordance with the provisions of N.J.S.A. 45:11-45 et seq. and this subchapter:

1. Community Health;
2. Gerontological;
3. Neonatal;
4. Maternal/Child;
5. Adult Health;
6. Psychiatric/Mental Health;
7. Oncology; and
8. Pediatric

(c) Other categories may be approved by the Board through the rulemaking process. Consistent with requirements for approval of the practice areas outlined in (a) and (b) above, any additional approved practice areas must meet nationally accepted standards.

13:37-7.12 Reporting

(a) Each nurse practitioner/clinical nurse specialist shall immediately notify the Board in writing upon the following:

1. Failure to renew or maintain, on a biennial basis, certification as a nurse practitioner/clinical nurse specialist;
2. Use of alcohol or drugs which has adversely impaired or adversely impairs nursing practice;
3. Current indictment and/or conviction of a crime involving moral turpitude and/or a crime relating adversely to nursing practice;
4. Being a named defendant or respondent in a civil, criminal, or administrative investigation, complaint and/or judgment involving alleged malpractice, negligence, or misconduct relating to practice as a nurse practitioner/clinical nurse specialist; or
5. Voluntary license surrender or any disciplinary action against the nurse practitioner/clinical nurse specialist by any state or Federal agency, board or commission, including any order of limitation or preclusion.

(b) A nurse practitioner/clinical nurse specialist who violates any provision of the Nurse Practice Act, N.J.S.A. 45:11-23 et seq. or N.J.S.A. 45:1-14 et seq. may, upon notice to the licensee and the opportunity for 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, be subject to disciplinary action by the Board including a restriction on practice.

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Speed Limits

Route N.J. 41 in Gloucester, Camden and Burlington Counties

Proposed Amendment: N.J.A.C. 16:28-1.33

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-98.
Proposal Number: PRN 1993-360.

Submit comments by August 4, 1993 to:
Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to amend N.J.A.C. 16:28-1.33 to establish revised descriptions of the limits of the speed zones along Route N.J. 41 in Deptford Township, Gloucester County; Runnemede Borough-Gloucester Township and Cherry Hill Township, Camden County; and Maple Shade Township, Burlington County. The proposed amendments do not change speed limits, but adjust the mileposts defining the limits of the various speed zones.

Based upon requests from local government, the Department's Bureau of Traffic Engineering and Safety Programs conducted a review which revealed that the establishment of the revised descriptions of the speed limit zones was warranted.

Social Impact

The proposed amendment will adjust the limits of the "speed limit" zones along Route N.J. 41 in Deptford Township, Gloucester County; Borough of Runnemede-Gloucester Township and Cherry Hill Township, Camden County; and Maple Shade Township, Burlington County for the efficient flow of traffic, the enhancement of safety, and the well-being of the populace. Appropriate signs will be erected to advise the motoring public.

Economic Impact

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

Regulatory Flexibility Statement

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

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

16:28-1.33 Route 41

(a) The rate of speed designated for State highway Route 41 described in this [section] **subsection** shall be established and adopted as the maximum legal rate of speed [thereat]:

1. For both directions of traffic:

[i. Zone 1: 50 mph from the intersection with Route 47 to the intersection with County House Road, Deptford Township (milepost 0.0 to 1.55); thence

ii. Zone 2: 45 mph to the intersection with Clements Bridge Road (County Road 544, milepost 3.9); thence

iii. Zone 3: 35 mph to the intersection with Read Avenue, Runnemede Borough (milepost 4.7); thence

iv. Zone 4: 30 mph to the intersection with Route 168 (milepost 4.95);[1]

v. Zone 5: 45 mph between Route 41 and 70 Traffic Circle (milepost 10.6) and Knollwood Drive, (milepost 11.95), Cherry Hill Township, Camden County; thence

vi. Zone 6: 45 mph to the Cherry Hill-Mapleshade Township line (milepost 13.1) and within the corporate limits of Mapleshade Township (milepost 13.1 to 14.13).

[1]From mileposts 4.95 to 10.6, the legal speed limit is under county jurisdiction.]

i. In Gloucester County:

(1) Deptford Township:

(A) Zone 1: 50 miles per hour between Egg Harbor Road (County Road 630)—Delsea Drive (Route N.J. 47) and County House Road (County Road 621) (approximate mileposts 0.00 to 1.56); thence

(B) Zone 2: 45 miles per hour between County House Road and Clements Bridge Road (County Road 544) (approximate mileposts 1.56 to 3.86); thence

(C) Zone 3: 35 miles per hour between Clements Bridge Road and the Borough of Runnemede, Township of Gloucester-Township of Deptford corporate line (approximate mileposts 3.86 to 4.12).

ii. In Camden County:

(1) Borough of Runnemede-Gloucester Township:

(A) Zone 1: 35 miles per hour between the Township of Deptford-Borough of Runnemede, Gloucester Township corporate line and Read Avenue (approximate mileposts 4.12 to 4.70); thence

(B) Zone 2: 30 miles per hour between Read Avenue and Route N.J. 168 (Black Horse Pike) (approximate mileposts 4.70 to 4.95) (Note: The roadway between Route N.J. 168 and Route N.J. 70 in Cherry Hill Township is under county jurisdiction; however, the roadway is signed Temporary Route N.J 41 (approximate mileposts 4.95 to 10.74); thence

(2) Cherry Hill Township:

(A) Zone 1: 45 miles per hour from the roadway between the Borough of Haddonfield-Township of Cherry Hill corporate line and Route 70 (Marlton Pike) under county jurisdiction; however, the roadway is signed as Temporary Route N.J. 41 (approximate mileposts 9.75 to 10.74); thence

(B) Zone 2: 45 miles per hour between Route N.J. 70 (Marlton Turnpike) and the Maple Shade Township-Cherry Hill Township corporate line (approximate mileposts 10.74 to 13.10).

iii. In Burlington County:

(1) Maple Shade Township:

(A) 45 miles per hour between the Cherry Hill Township-Maple Shade Township corporate line and the northerly terminus of Route N.J. 41 at Kings Highway (County Road 611) (approximate mileposts 13.10 to 13.98).

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Speed Limits
Route N.J. 169 in Hudson County
Proposed Amendment: N.J.A.C. 16:28-1.92

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

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-98.

Proposal Number: PRN 1993-359.

Submit comments by August 4, 1993 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to amend N.J.A.C. 16:28-1.92 to establish revised "speed limit" zones along Route N.J. 169 in the Cities of Bayonne and Jersey City, Hudson County, for the efficient flow of traffic, the enhancement of safety, and the well-being of the populace.

Based upon a local government request, and as part of a review of current conditions, the Department's Bureau of Traffic Engineering and Safety Programs conducted a traffic investigation. The investigation proved that the establishment of revised "speed limit" zones along Route N.J. 169 in the Cities of Bayonne and Jersey City, Hudson County, was warranted.

Appropriate signs shall be erected in areas where the speed limit zones have been changed.

Social Impact

The proposed amendment will establish revised "speed limit" zones along Route N.J. 169 in the Cities of Bayonne and Jersey City, Hudson County, for the efficient flow of traffic, the enhancement of safety, and the well-being of the populace. Appropriate signs will be erected to advise the motoring public.

Economic Impact

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

Regulatory Flexibility Statement

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

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

16:28-1.92 Route 169

(a) The rate of speed designated for the certain parts of State highway Route [number] 169 described in this [section] **subsection** shall be established and adopted as the maximum legal rate of speed [thereat]:

1. For both directions of traffic in the City of Bayonne, and the City of Jersey City, Hudson County;

[i. Zone 1: 40 miles per hour between 500 feet south of 30th Street and Prospect Avenue (milepost 2.75 to 3.2); thence

ii. Zone 2: 45 miles per hour between Prospect Avenue and Pulaski Street (milepost 3.2 to 4.0); thence

iii. Zone 3: 40 miles per hour between Pulaski Street and Garfield Avenue (milepost 4.0 to 4.9); thence

iv. Zone 4: 35 miles per hour between Garfield Avenue and 2,112 feet north of the northernmost leg of John F. Kennedy Boulevard (milepost 4.9 to 5.73).]

i. Zone 1: 50 miles per hour between the New York and New Jersey Port Authority-New Jersey Department of Transportation jurisdiction line and Hook Road (approximate milepost 0.00 to 2.25); thence

ii. Zone 2: 40 miles per hour between Hook Road and 500 feet north of Prospect Avenue (approximate mileposts 2.25 to 3.30); thence

iii. Zone 3: 45 miles per hour between 500 feet north of Prospect Avenue and Pulaski Street (approximate mileposts 3.30 to 4.00); thence

iv. Zone 4: 35 miles per hour between Pulaski Street and 500 feet north of the New Jersey Turnpike Overpass (approximate mileposts 4.00 to 4.65); thence

v. Zone 5: 50 miles per hour between 500 feet north of the New Jersey Turnpike Overpass and the junction of Route N.J. 169-Route N.J. 440 (approximate mileposts 4.65 to 5.73).

(b)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Restricted Parking and Stopping
Routes N.J. 57 in Warren County
Proposed Amendment: N.J.A.C. 16:28A-1.36

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

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-198 and 39:4-199.

Proposal Number: PRN 1993-353.

Submit comments by August 4, 1993 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to amend N.J.A.C. 16:28A-1.36 to establish a "no stopping or standing" zone along Route N.J. 57 (Flower Avenue) in the Borough of Washington, Warren County. The provisions of this amendment will improve the flow of traffic and enhance safety along the highway system.

This amendment is being proposed at the request of the Borough of Washington (by Resolution No. 55-92 adopted May 19, 1992), and as part of the Department's on-going review of current conditions. The traffic investigation conducted by the Department's Bureau of Traffic Engineering and Safety Programs proved that the establishment of a "no

stopping or standing" zone along Route N.J. 57 (Flower Avenue) in the Borough of Washington, Warren County was warranted. Appropriate signs will be erected to advise the motorists.

Social Impact

The proposed amendment will establish parking restrictions along Route N.J. 57 in the Borough of Washington, Warren County, to improve flow of traffic, and enhance safety. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will pay for the installation of "no stopping or standing" zone signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size, and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

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

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

16:28A-1.36 Route 57

(a) The certain parts of State highway Route 57 described in this subsection are designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs [must] **shall** be erected.

1.-2. (No change.)

3. No stopping or standing in Washington Borough, Warren County:

i.-ii. (No change.)

iii. Along the [north] **northerly side:**

(1) (No change.)

(2) From a point 150 feet east of the easterly curb line of Flower Avenue to a point 150 feet west of the westerly curb line of Flower Avenue.

4.-6. (No change.)

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

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Turn Prohibitions

Routes U.S. 30 in Camden County; N.J. 36 in Monmouth County; N.J. 73 in Camden County; and U.S. 130 in Burlington and Mercer Counties

Proposed Amendments: N.J.A.C. 16:31-1.10, 1.17 and 1.22

Proposed New Rule: N.J.A.C. 16:31-1.32

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

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-123 and 39:4-183.6 and 39:4-199.1.

Proposal Number: PRN 1993-358.

Submit comments by August 4, 1993 to:

Charles L. Myers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to amend existing rules and establish a new rule concerning turning movements along various highways in the following counties and municipalities.

N.J.A.C. 16:31-1.10, Route U.S. 30, is being amended to effect "no left turn" in Waterford Township, Camden County. This rule has been further recodified in compliance with the Department's rulemaking format.

N.J.A.C. 16:31-1.17, Route 73, is being amended to effect "no left turn" in Winslow Township, Camden County from northbound on Route N.J. 73 to northwest bound on New Brooklyn-Cedarbrook Road (County Road 536).

N.J.A.C. 16:32-1.22, Route U.S. 130, is being amended to effect a no "U" turn regulation for trucks over four tons registered gross weight in Bordentown Township, Burlington County, and in Hamilton and Washington Townships, Mercer County.

N.J.A.C. 16:31-1.32, Route 36, is a new rule effecting "no left turn" from Route N.J. 36 southbound into the entrance to Gateway National Park in Sea Bright Borough, Monmouth County.

The provision of these amendments and new rule will improve the flow of traffic and enhance safety along the highway system.

These amendments and new rule are being proposed at the request of various municipal governments, and as part of the Department's ongoing review of current conditions. The traffic investigation conducted by the Department's Bureau of Traffic Engineering and Safety Programs proved that the establishment of the turning movement restrictions along Routes U.S. 30 in Waterford Township, Camden County; N.J. 73 in Winslow Township, Camden County; U.S. 130 in Bordentown Township, Burlington County and Hamilton and Washington Townships, Mercer County; and N.J. 36 in Sea Bright Borough, Monmouth County was warranted. Signs are required to notify motorists of the restrictions proposed herein.

Social Impact

The proposed amendments and new rule will establish turn restrictions along Route U.S. 30 in Waterford Township, Camden County; N.J. 73 in Winslow Township, Camden County; U.S. 130 in Bordentown Township, Burlington County and Hamilton and Washington Townships, Mercer County; and N.J. 36 in Sea Bright Borough, Monmouth County, to improve traffic safety. Appropriate signs will be erected to advise the motoring public.

Economic Impact

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

Regulatory Flexibility Statement

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

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

16:31-1.10 Route U.S. 30

(a) Turning movements of traffic on the certain parts **of State highway** Route U.S. 30 described [herein below] **in this subsection** are regulated as follows:

1. No left turns:

[i. East on Route U.S. 30 to north on Station Avenue, City of Absecon, Atlantic County;

ii. Westerly on Route U.S. 30 to southerly on Illinois Avenue.]

i. In the City of Absecon, Atlantic County:

(1) From east on Route U.S. 30 to north on Station Avenue;

(2) From west on Route U.S. 30 to south on Illinois Avenue.

ii. In the Township of Waterford, Camden County:

(1) From east on Route U.S. 30 to north into the driveways of Block 202, Lot 2, located approximately 480 feet west of the centerline of Leitz Lane (approximate mile post 18.54).

16:31-1.17 Route 73

(a) Turning movements of traffic on the certain parts of State highway Route 73 described in this subsection are regulated as follows:

1. No left turn in Camden County:

i. In Winslow Township:

(1) (No change.)

(2) From northbound on Route N.J. 73 to northwest bound on New Brooklyn-Cedarbrook Road (County Road 536) at the most southerly intersection only (approximate milepost 10.4).

2.-3. (No change.)

16:31-1.22 Route U.S. 130

(a) Turning movements of traffic [in] **on** certain parts of **State highway** Route U.S. 130 described in this subsection are regulated as follows:

1.-3. (No change.)

4. No "U" turns for trucks over four tons registered gross weight:

i. In Bordentown Township, Burlington County; and

ii. In Hamilton and Washington Townships, Mercer County:

(1) Along Route U.S. 130 northbound from milepost 56.6 to milepost 64.0.

(2) Along Route U.S. 130 southbound from milepost 64.0 to milepost 56.6.

16:31-1.32 Route 36

(a) Turning movements of traffic on certain parts of State highway Route N.J. 36 described in this subsection are regulated as follows:

1. No left turn:

i. In Sea Bright Borough, Monmouth County:

(1) From Route N.J. 36 southbound into the entrance to Gateway National Park.

(a)

REGIONAL OPERATIONS, REGION V OFFICE OF OUTDOOR ADVERTISING SERVICES

Motorist Service Signing for Non-Urban Interstate and Limited Access Highways

Proposed New Rules: N.J.A.C. 16:41D

Authorized By: William D. Ankner, Director, Division of Policy and Capital Programming.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 27:1A-44, 27:5-10, 27:5-11, 27:5-12, 27:7-21, 39:4-183.1, 39:4-183.6 and 39:4-183.27.

Proposal Number: PRN 1993-370.

A **public hearing** concerning the proposed new rules will be held on Wednesday, July 21, 1993, at 1:00 P.M. to 3:00 P.M. at the following address:

New Jersey Department of Transportation
Engineering and Operations Building
Multi-Purpose Room, 1st Floor
1035 Parkway Avenue
Trenton, New Jersey 08625

The hearing record closes August 4, 1993.

Submit written comments by August 4, 1993 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The "Manual On Uniform Traffic Control Devices" (MUTCD) is published by the U.S. Department of Transportation, Federal Highway Administration. The MUTCD prescribes national uniform standards for all traffic control devices. Traffic control devices are signs, signals, markings, and devices placed on, over, or adjacent to a street or highway by public agencies. Traffic control devices which are erected or maintained by the Department of Transportation must be in conformance with the MUTCD.

One of the specific service signing programs recognized in the MUTCD is "Motorist Service Signing," sometimes referred to as "logo" signing. The MUTCD sections regarding this program are found at 2G-5.1 et seq. in the current 1988 edition of the manual. The specific purpose of this program is to provide to the public who are travelling on non-urban interstate and limited access highways timely and specific directions to nearby gas, fuel, food, lodging, and camping services readily accessible from highway exits. The MUTCD provides that these service signs may include a business logo to specifically identify the name, brand, or trademark of the gas, fuel, food, lodging, or camping business to which the signs direct motorists. Over 40 states have "logo" sign programs for their non-urban interstate and limited access highways.

Logo signs are allowed on interstate highways and limited access highways by the Manual on Uniform Traffic Control Devices, in order to provide business identification and directional information for essential motorist services.

The rules proposed herein outline New Jersey Department of Transportation procedures and requirements for businesses which may wish to voluntarily participate in a motorist service sign program. The proposed rules establish standards and requirements for logo signing on New Jersey highways pursuant to parts 2G-5.1 et seq. of the MUTCD. Application procedures are outlined in detail. Implementation of this program will be done in a manner compatible with all applicable United States Department of Transportation and Federal Highway Administration requirements.

The proposed new chapter is summarized as follows:

Subchapter 1 outlines the general provisions of the rules. This includes a description of the purpose of the rules, the scope of highways subject to the rules, and the definition and meaning of key terms used in the rules.

Subchapter 2 outlines general and specific eligibility requirements for businesses who wish to participate in the logo service signing program. Businesses which can participate in the program are those which are the closest to the highway and which provide fuel, food, lodging, and camping facility services. The program conforms with national standards for roadside signs as approved in the "Manual On Uniform Traffic Control Devices."

Subchapter 3 outlines program application procedures, criteria to be used by the Department in selecting participating businesses, and fees. This subchapter requires that a participating business enter into a written agreement with the Department. The agreement may be terminated if the business does not comply with the provisions of the chapter. The subchapter also outlines procedures regarding the "bumping rights" of eligible businesses.

Subchapter 4 describes the appeals procedures of the Department applicable to this program.

Subchapter 5 outlines provisions regarding the construction and maintenance of signs by the Department. Department duties include periodic inspection, maintenance, and replacement of service signs.

Subchapter 6 provides that the Department may terminate any agreement, or any portion of the program, and only be liable for pro-rata reimbursement of fees paid by participating business. The Department will specify which routes and intersections are available for logo service signing.

Social Impact

The rules proposed herein will permit the motoring public on non-urban interstate and limited access highways to be better informed about the availability of the closest fuel, food, lodging, and campsite services. This information is of particular significance and value to individuals who are travelling longer distances and may not be familiar with local businesses that are easily accessible, but not visible, from the highway. Logo signs are expected to have the incidental effect of promoting local commerce by attracting customers from the highways. The Department believes that the social impact of the proposed rule is distinctly positive and that the public and participating businesses will directly benefit from this new program.

Economic Impact

The proposed rules are expected to have varying economic impacts upon the different groups of persons affected by them. Businesses participating in the program are required to pay certain nonrefundable fees to the Department of Transportation. There is a one time application fee of $300.00, a one time fabrication and installation fee of $7,450, an annual maintenance fee of $1,170, and a design change fee of $1,950 if the participating business changes its logo design. For a participating business, the first year program cost will be approximately $7,750. Each subsequent year would cost approximately $1,170. If a business changes its logo design, the fabrication and replacement cost is a one time fee of $1,950.

Each fee offsets the costs incurred by the State for implementing this program. The Department of Transportation expects to fiscally "break even" on this program. Start-up and annual fees have been set on a unit cost basis to cover actual program implementation costs.

The logo sign program is expected to have the positive, but incidental, effect of promoting local commerce by attracting customers from the highway. Each business interested in participating in this program will have to independently do its own cost benefit analysis and act accordingly. It is expected, therefore, that virtually every business participating in this program will have determined that it is economically beneficial for their particular business. The Department expects that some national franchise businesses may have increased interest in building in the State as a result of the increased customer exposure that results from the installation of logo service signs.

Motorists will have the benefit of better service signing as a result of this program. However, no fees or costs will be imposed upon them or the general public as a result of this program.

The Department expects that more than 100 interstate and limited access highway intersections will ultimately have logo service signing. Full Statewide implementation of the program is expected to take more than a year. The Department expects there to be substantial interest in this program but does not have a market study indicating how many businesses may wish to participate in this program.

Regulatory Flexibility Analysis

While the proposed new rules govern an optional program, those businesses wishing to participate will be regulated by this chapter. Some of the businesses expected to participate may be large franchises; however, many may be considered small businesses, as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. As indicated in the statement of economic impact, the average cost to a business for its first year of participation will be approximately $7,750. Thereafter, the annual cost would drop to $1,170. The fees are based upon the total staff time and other costs required for Department application review, sign fabrication, installation, monitoring, and maintenance which would not vary significantly by the size or type of business or by any other requirement specified in the proposed rules. The Department, therefore, has determined that no differentiation based upon business size is appropriate or necessary in these rules. A business participating in this program will have to certify that it is in compliance with applicable State and local regulations on health and public accommodation. There are no requirements placed on businesses not participating in the program.

Full text of the proposed new rules follows:

CHAPTER 41D
MOTORIST SERVICE SIGNING FOR NON-URBAN INTERSTATE AND LIMITED ACCESS HIGHWAYS

SUBCHAPTER 1. GENERAL PROVISIONS

16:41D-1.1 Purpose

(a) The purpose of this chapter is to establish procedures and policies applicable to a NJDOT official MUTCD and Federal Highway Administration approved motorist service and logo sign program for providing fuel, food, lodging and campsite information to the traveling public. Such signs are to be owned, erected and maintained by the NJDOT, paid by participating businesses, and placed near selected intersections on NJDOT right-of-way on non-urban interstate highways and limited access primary highway routes.

(b) The program will be managed by the NJDOT exclusively for the benefit of the motoring public and in a manner consistent with applicable MUTCD and Federal Highway Administration guidelines.

16:41D-1.2 Scope

This chapter will govern motorist service signs erected by the Department within the right-of-way of non-urban interstate and limited-access State highways.

16:41D-1.3 Definitions

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

"Business" means an individual facility that furnishes fuel, food, lodging or camping services to the motoring public.

"Commissioner" means the Commissioner of the New Jersey Department of Transportation.

"Department" or "NJDOT" means the New Jersey Department of Transportation.

"Interstate highway" means a highway constructed within this State and approved by the Secretary of Transportation of the United States as an official portion of the National System of Interstate and Defense Highways pursuant to the provisions of Title 23, "Highways," of the United States Code, as amended.

"Limited access highway" means a highway especially designed for through traffic over which abutters have no easement or right of light, air or direct access, by reason of the fact that their property abuts such way.

"Logo sign panel" means a separate sign which shows a brand, symbol, trademark or name, or combination thereof, and which is designed to be mounted on a service sign.

"Manual On Uniform Traffic Control Devices" or "MUTCD" means the Manual On Uniform Traffic Control Devices for streets and highways as periodically published and revised by the United States Department of Transportation, Federal Highway Administration, available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

"Public telephone" means a coin operated telephone on site or in the immediate vicinity and which is available for public use during all business hours.

"Service sign" means an official sign, erected by the Department, within the highway right-of-way which indicates to motorists that general types of services, such as fuel, food, lodging and camping are available and which are designed to cary logo sign panels.

SUBCHAPTER 2. ELIGIBILITY AND REQUIREMENTS

16:41D-2.1 Eligibility

To be eligible to participate in the service signing program, each business must remain in conformance with all applicable local, State and Federal laws concerning public accommodations and provide fuel, food, lodging or camping accommodations in the manner prescribed in N.J.A.C. 16:41D-2.2.

16:41D-2.2 Specific requirements

(a) Each participating business shall at all times satisfy the specific requirements established for its industry type, as follows:

1. Fuel facilities shall:

i. Be licensed by all appropriate authorities;

ii. Have gas, fuel and oil to cars, trucks and other vehicles;
iii. Have free public rest rooms;
iv. Have a public telephone;
v. Be in continuous operation for at least 16 hours each day and seven days each week throughout the year; and
vi. Be located within three miles of the highway.
2. Food facilities shall:
i. Be licensed by all appropriate authorities and possess valid permits from all appropriate health departments;
ii. Have a public telephone;
iii. Have free public rest rooms;
iv. Be in continuous operation at least 12 hours each day and seven days each week throughout the year; and
v. Be located within three miles of the highway.
3. Lodging facilities shall:
i. Be licensed by all appropriate authorities and possess valid permits from all appropriate health departments;
ii. Have at least 10 units, each with a private bath;
iii. Have off street parking for each unit;
iv. Have a public telephone;
v. Be in continuous operation seven days each week throughout the year; and
vi. Be located within three miles of the highway.
4. Camping facilities shall:
i. Be licensed by all appropriate authorities and possess valid permits from all appropriate health departments;
ii. Have restrooms and showers;
iii. Provide drinking water;
iv. Have public telephones; and
v. Be located within seven miles of the highway.

(b) If, at any designated intersection there are no eligible businesses of a particular industry type, the Department, at its sole discretion, may waive the locational requirements set forth in (a)1vi, 2v, 3vi and 4v above and extend eligibility to other businesses which satisfy the remaining requirements pertaining to that industry type.

16:41D-2.3 Measurement of distances

The measurement of distances from an interstate highway or limited access highway shall be from the centerline between the main lines of the highway and shall be measured along the intersecting roadway to the property line of the particular business.

16:41D-2.4 Seasonal campgrounds

Seasonal campgrounds shall notify the Office of Outdoor Advertising Services 60 days in advance of their opening and closing dates so that the Department may remove or cover the logo sign during the period when the campground is closed.

16:41D-2.5 Temporary closure of participating business

(a) Any participating business which closes temporarily for repairs or emergencies shall not be found to be in violation of the specific requirement concerning continuous operation set forth in N.J.A.C. 16:41D-2.2 provided that:

1. The business shall notify the Office of Outdoor Advertising Services 15 days before a planned temporary closure;
2. The business shall notify the Office of Outdoor Advertising Services within three days of a closure necessitated by an emergency;
3. The duration of the closure shall not exceed seven days, except that the Office of Outdoor Advertising Services may, in its discretion, extend this period for good cause where the public interest is not adversely affected, which extension shall not exceed 30 days;
4. When a business reopens after a temporary closure it shall notify the Office of Outdoor Advertising Services. The Department shall replace or uncover any logo sign panel which it removed or covered within a reasonable period; and
5. During the period of closure the Department may, in its sole discretion, remove or cover up the logo sign panel of the participating business.

SUBCHAPTER 3. APPLICATION AND SELECTION PROCEDURES

16:41D-3.1 Application procedures and fees

All businesses shall make application on the forms and in the manner prescribed by the Department and shall pay a non-refundable application fee of $300.00. Applicants shall include on the form pertinent identifying information and documentation of compliance with N.J.A.C. 16:41D-2. Businesses which are determined to be ineligible shall be so notified by the Office of Outdoor Advertising Services.

16:41D-3.2 Selection of participating businesses

(a) The Department shall select participating business of each industry type from a list of eligible business which have submitted complete applications and paid the application fee.

(b) Participation shall be offered to as many business as can be accommodated on the service sign of its industry type in accordance with the MUTCD.

(c) If there are more businesses than can be accommodated on a service sign, the Department shall select the businesses which are closest to the highway.

1. The Department shall place any unselected business on a waiting list for the service sign of its particular industry type and shall notify these businesses of their placement on the waiting list.
2. A business which has been on the waiting list for three years may notify the Office of Outdoor Advertising Services of its intention to bump a participating business of the same industry type which is further from the highway. The Office of Outdoor Advertising Services shall determine which business is closer and shall select the closest business to participate. Within 30 days of its receipt of the notice of intention to bump, the Office of Outdoor Advertising Services shall notify both businesses of the business which has been selected to participate.

16:41D-3.3 Agreements

(a) After selection for participation in the program, each business shall enter into a written agreement with the Department allocating responsibilities for the logo sign panel.

1. The initial agreement shall be for three years provided that the business has paid all annual fees, in accordance with this chapter, and annually certifies that it meets all eligibility requirements. Thereafter, the agreement shall be extended each year, provided that the business has paid all fees in accordance with this chapter, certifies that it meets all eligibility requirements, and has not been bumped pursuant to N.J.A.C. 16:41D-3.2(c)2.
2. If the Department determines that a participating business does not comply with the requirements of this chapter, the Department shall direct the business to comply within 30 days. If the business does not comply within 30 days of the Department's directive, the business shall be deemed to be in breach of the agreement and the Department may remove or cover its logo sign panel, terminate the agreement, and allocate the panel space to another eligible business.

16:41D-3.4 Fees

(a) Each participating business shall be charged the following non-refundable fees:

1. Annual renewal and maintenance fee (This is a recurring annual fee)	$1,170
2. Design, fabrication and installation fee (This is a one time initial fee)	$7,450
3. Design change, fabrication and installation fee (Charged only if there is a logo design change)	$1,950

(b) Eligible businesses which are placed on a waiting list pursuant to N.J.A.C. 16:41D-3.2(c) are not required to pay any annual fee until they participate in the program.

SUBCHAPTER 4. APPEALS

16:41D-4.1 Appeals

(a) Any business that has been determined to be ineligible or has been denied participation in the logo sign program or has been bumped may submit a written request for reconsideration to the

Executive Director in charge of the logo sign program within 10 days of notice from the Office of Outdoor Advertising Services. The request shall include the reasons for the requested reconsideration. The Executive Director, Division of Regional Operations, shall schedule an informal meeting within 30 days of his or her receipt of the request.

(b) At the reconsideration meeting, the aggrieved business will be accorded an opportunity to present additional information in support of its desire to be an eligible participant in the logo sign program.

(c) The Executive Director shall render a final agency decision within 10 days of the informal meeting and shall so notify the businesses in writing.

SUBCHAPTER 5. CONSTRUCTION AND MAINTENANCE OF SIGNS

16:41D-5.1 Fabrication and installation

Logo sign panels and service signs shall be fabricated and installed by the Department in accordance with the standards for specific service signing in the MUTCD, as amended or superseded.

16:41D-5.2 Inspection and maintenance

The Department will conduct routine inspections of the service signs, and logo sign panels and perform maintenance, repairs or replacement as required.

16:41D-5.3 Replacement of signs

Service signs will be scheduled for replacement every 10 years, as needed. Logo sign panels will be scheduled for replacement every five years, as needed. Posts and other hardware will be replaced as necessary. Any sign panel that has been destroyed or vandalized will be replaced by the Department as soon as practicable after the Office of Outdoor Advertising Services has received written notice of such destruction.

SUBCHAPTER 6. TERMINATION AND LOCATIONS

16:41D-6.1 Agreement termination

The NJDOT may terminate any agreement or any portion of this program and shall only be liable for the pro-rata reimbursement of fees paid by participating businesses.

16:41D-6.2 Service sign location

The Department reserves the right to specify the routes and intersections available for logo service signing.

TREASURY-GENERAL

(a)

STATE INVESTMENT COUNCIL

State of New Jersey Cash Management Fund Permissible Investments

Proposed Amendment: N.J.A.C. 17:16-61.5

Authorized By: State Investment Council, Roland M. Machold, Director, Division of Investment.

Authority: N.J.S.A. 52:18A-91.

Proposal Number: PRN 1993-357.

Submit comments by August 4, 1993 to:

Roland M. Machold
Administrative Practice Officer
Division of Investment
CN 290
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendment would permit the Division of Investment to have greater flexibility in the management of the investments in the State of New Jersey Cash Management Fund by: (1) permitting up to 25 percent of the fund to be invested in securities maturing within two years, rather than one year, as is the case with all investments at present, and (2) permitting investment in long-term bonds which have been called for redemption and whose maturity has in effect been shortened to the point where they would be eligible for the Fund.

Social Impact

The proposed amendment will provide the Fund the opportunity to increase the yield of the Fund slightly (.10 percent to .15 percent) at such times as the market yield curve is sharply positive. Increased yields will provide increased revenues to the State and municipal participants to fund social services.

Economic Impact

Higher potential yields on the Cash Management Fund will, on the margin, provide the opportunity for increased revenue to Fund participants, which in turn will help fund State and local services and reduce reliance on tax revenues.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required, since the proposed amendment has no effect on small businesses as the term is defined in N.J.S.A. 52:14B-16 et seq., but regulates only the Director of the Division of Investment.

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

17:16-61.5 Permissible investments

The Director may invest the assets of the State of New Jersey Cash Management Fund in fixed-income and debt securities which are legal investments for savings banks, or which are permitted under the provisions of N.J.S.A. 52:18A-89, subject to any applicable provisions of the regulations of the State Investment Council[, and which mature within one year]. **All investments in the fund shall mature or are to be redeemed within one year, except that up to 25 percent of the fund may be invested in eligible securities which mature within two years; provided, however, that the average maturity of all investments in the fund shall not exceed one year.**

OTHER AGENCIES

(b)

NEW JERSEY TURNPIKE AUTHORITY

New Jersey Turnpike Authority Rules

Proposed Readoption with Amendments: N.J.A.C. 19:9

Authorized By: New Jersey Turnpike Authority, Herbert I. Olarsch, Administrative Practices Officer.

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

Proposal Number: PRN 1993-374.

Submit comments by August 4, 1993, to:

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

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 19:9 expires October 17, 1993. The Turnpike Authority has reviewed the rules set forth therein and, with the exception of the rules proposed to be deleted or amended as described below, has determined that they continue to be necessary, reasonable and proper for the purposes for which they were originally promulgated. The rules augment the provisions of the Turnpike Authority's enabling statute and provide an efficient and effective mechanism for the regulation and safe and efficient use of the New Jersey Turnpike by those who travel on it and are situated near it. The rules also provide an effective means for the proper administration of the Turnpike Authority so as to fulfill the mandate of its enabling legislation.

In the course of its review pursuant to Executive Order No. 66, the Turnpike Authority identified stylistic and grammatical inconsistencies,

outdated references and gender-specific references in its rules. Appropriate technical amendments are proposed throughout N.J.A.C. 19:9 to conform and update references and to make all references gender-neutral. Technical amendments are not specifically analyzed in this Summary unless an amendment would cause a substantive change to the rules. The Turnpike Authority solicits comments regarding whether any of the proposed technical amendments would cause a substantive change that should be considered by the Turnpike Authority before promulgation.

Subchapter 1 contains the traffic control regulations governing the operation of vehicles on the New Jersey Turnpike, as well as definitions applicable to the entire chapter.

A new definition is proposed for the Interstate 95 Extension in Bergen County, over which the Turnpike Authority has assumed jurisdiction pursuant to P.L. 1991, c.183, to distinguish it from the rest of the Turnpike roadway. This distinction is necessary because certain of the Turnpike Authority's regulations may not be enforceable on the I-95 Extension inasmuch as Federal funds were used to fund original construction and continue to be used for maintenance. The definition of the term "Authority" is proposed to be revised to make clear that acts of the Turnpike Authority's duly designated officers and employees are acts of the Turnpike Authority itself. The definition of "omnibus" is proposed to be revised to conform with the existing definition used by the Turnpike Authority's Toll Collection Department for purposes of determining the toll classification of vehicles carrying passengers for hire on the Turnpike.

Changes of a primarily grammatical nature are proposed to the rule requiring obedience to posted speed limits. However, the Turnpike Authority also proposes language to make clear that irrespective of the posted speed limit, motorists are required to operate vehicles at speeds appropriate to existing roadway or weather conditions or other hazards. Minor revisions are proposed to clarify existing prohibitions on the use of flashing emergency lights (N.J.A.C. 19:9-1.3), driving against traffic (N.J.A.C. 19:9-1.4), "U" turns (N.J.A.C. 19:9-1.5), parking or stopping on the Turnpike (N.J.A.C. 19:9-1.6), and use of the medial strip (N.J.A.C. 19:9-1.7) and to clarify the categories of vehicles excepted from these prohibitions. In addition, the Turnpike Authority proposes to require motorists whose vehicles are impounded for improper parking or stopping on the Turnpike to pay storage fees in addition to the towing fees presently required. N.J.A.C. 19:9-1.6(i). The Turnpike Authority also proposes to eliminate the innocent owner defense to liability for towing and storage costs of towing. N.J.A.C. 19:9-1.6(j). The Turnpike Authority has no record of any motorists asserting this provision in the past, which calls into question the need for such a provision.

The Turnpike Authority also proposes to amend current N.J.A.C. 19:9-1.6(k) as N.J.A.C. 19:9-1.6(j) with revisions to conform with the Appellate Division ruling in *State v. Levinson,* 225 *N.J. Super.* 135 (1988). In *Levinson,* the Appellate Division held that the photography ban presently set forth in N.J.A.C. 19:9-1.6(k) was beyond the scope of the Turnpike Authority's powers. The Turnpike Authority proposes to permit the taking of photographs on the Turnpike where such activities are not potentially injurious to the health, safety and welfare of motorists, the general public or the Turnpike Authority. The Turnpike Authority finds it necessary, reasonable and proper to strictly regulate the presence of pedestrians and stopped vehicles on the Turnpike for the non-essential purpose of taking photographs because of the documented risk of death or severe injury posed by passing vehicles to persons standing on or near the Turnpike. The Turnpike Authority's need to strictly regulate such photography is also raised by the number of requests by film and television crews to shoot on or next to the Turnpike. Permitting uncontrolled access for photographic purposes poses an unreasonable risk to photographic crews and motorists. Accordingly, the Turnpike Authority will permit photography when permission is duly requested and appropriate safety measures can be taken to insure health, safety and welfare. In addition, the Turnpike Authority will continue to undertake photographic services for third parties pursuant to current N.J.A.C. 19:9-4.2(b), proposed to be readopted as N.J.A.C. 19:9-4.1(e).

The Turnpike Authority proposes a number of amendments, most of which are technical or grammatical, to the rules setting forth the vehicles prohibited from the Turnpike. The Turnpike Authority has reviewed, by vehicle category, the need to continue the existing prohibitions, and it finds that the existing prohibitions remain necessary, reasonable and proper. The Turnpike Authority also proposes to correct the text of N.J.A.C. 19:9-1.9(a)12v to reflect the Turnpike Authority's original intent to pemrit motor vehicle carriers of up to 65 feet in length, rather than over 65 feet as presently provided. See 20 N.J.R. 1338(a).

The Turnpike Authority has found that in addition to the prohibition against vehicles with deflated tires, N.J.A.C. 19:9-1.9(a)7, it has become necessary to ban vehicles with overinflated tires. Turnpike Authority staff have observed a regional increase in the number of trucks becoming lodged under bridge structures and overpasses because overinflated tires have raised the overall height of the vehicle above the maximum clearance height. The tires on such vehicles are sometimes overinflated to compensate for an overweight load. In addition, recent research has shown that overinflated tires cause premature rutting of travel lanes, thereby degrading the safety of the Turnpike in adverse weather conditions and necessitating more frequent repair and maintenance work. Accordingly, the Turnpike Authority proposes to ban any vehicle with "improperly inflated" tires.

The Turnpike Authority also proposes to permit vehicles presently banned from the entire Turnpike, but which are operated pursuant to special permits issued by the Commissioner of Transportation, to be operated on the I-95 Extension pursuant to discussions between the Turnpike Authority and the New Jersey Department of Transportation. N.J.A.C. 19:9-1.9(a)13.

The proposed revisions to the rule concerning violations by members or employees of diplomatic missions, N.J.A.C. 19:9-1.9(a)22 are primarily intended to make that rule easier to understand and enforce. The only substantive change proposed in this regard is to permit State Police to escort drivers who have committed more than one violation of any of the Turnpike Authority's traffic control regulations off the Turnpike. The present rule permits such action only if the diplomatic member or employee has violated the Turnpike Authority's speed regulations more than once. The purpose of this rule is to ban from the Turnpike unsafe members and employees of diplomatic missions, who are immune from prosecution for traffic offenses by the doctrine of diplomatic immunity. Multiple violation of speed limits is one indicator of an unsafe driver. Violations of the Turnpike Authority's other traffic control regulations may likewise indicate an unsafe driver. Accordingly, multiple violations of any Turnpike Authority regulation would be sufficient ground for escorting the driver from the Turnpike.

The Turnpike Authority also proposes major revisions to subchapter 1 to more efficiently address the problem of cargo spills on the Turnpike. The increasing frequency of cargo spills, especially spills of hazardous materials, on New Jersey highways including the Turnpike has become a major problem impacting motorist safety, the environment, and the New Jersey economy. The Turnpike Authority has been working with other State and county agencies to provide and/or supervise hazardous substance spill response activities on the Turnpike. Notwithstanding these efforts, the Turnpike Authority has had difficulty on several occasions in gaining the operational and financial cooperation of drivers whose vehicles have spilled hazardous substances onto the Turnpike. Under Federal and State law, the driver and owner of the vehicle may be liable for the costs of cleaning up the discharge pursuant to CERCLA and/or the New Jersey Spill Act. Operators and owners who fail to cooperate with the Turnpike Authority's efforts are usually from outside New Jersey and, because they are unaware of the strict reporting and clean up thresholds imposed by New Jersey, refuse to cooperate. Failure to cooperate with the Turnpike Authority's efforts to assure swift clean up of such discharges can cause unnecessary delay, thus causing migration of the discharged substance into drainage ditches along the Turnpike and thence into the waters of the State and/or the United States. Failure to cooperate also delays the reopening of the Turnpike to traffic, unnecessarily exposing traffic stopped by reason of the discharge to the likelihood of rear-end collisions and impeding the free movement of goods and persons, thereby impacting the State and regional economies. The Turnpike Authority therefore finds it reasonable, necessary and proper to promulgate in its regulations a discharge response protocol setting forth the obligations of the operator or owner of a vehicle that has discharged a substance onto the Turnpike in order to notify and encourage owners and operators to cooperate with the Turnpike Authority in these situations.

Current N.J.A.C. 19:9-1.18 sets forth noise limits for the operation of vehicles on the Turnpike. For ease of administration and consistency with other roadways, the Turnpike Authority proposes to replace its maximum noise levels and measurement standards with the levels and standards promulgated by the Federal Highway Administration at 49 C.F.R. 325. Although enforcement of the Federal limits has been sharply curtailed elsewhere because of the lack of Federal funding for noise

enforcement efforts, users of the Turnpike are reminded that these limits may be enforced on the Turnpike in conjunction with routine traffic patrol activities.

Subchapter 2 contains the rules governing Turnpike Authority purchasing and contracting activities and protest procedures, surplus property procedures, and property crossing applications ("licenses to cross") and protest procedures.

The Turnpike Authority proposes to amend N.J.A.C. 19:9-2.2(c)9 to permit the Turnpike Authority to require consents of surety to be submitted by bidders; this will insure that the surety of a successful bidder is bound to issue a performance bond once the Turnpike Authority awards the contract to that bidder. This provision is necessary to guarantee performance of the contractor's contractual duties.

The Turnpike Authority proposes to amend N.J.A.C. 19:9-2.5 to provide that it may take advantage of the terms of contracts already entered into by multi-state agencies, and to permit the Turnpike Authority to conduct joint contracting with multi-state agencies. Presently, the regulations only permit the Turnpike Authority to procure from vendors who have contracts with State agencies, and only permit the Turnpike Authority to jointly contract with other agencies of the State of New Jersey. This provision would permit the Turnpike Authority to obtain goods and services under Port Authority of New York and New Jersey contracts so as to realize cost savings in those cases where the Port Authority's terms are more favorable than those of State contracts, and in those cases where the Turnpike Authority undertakes activities in conjunction with the Port Authority. Because the Turnpike serves several Port Authority facilities (that is, Newark International Airport, the Holland and Lincoln Tunnels, and the George Washington and Goethals Bridges), the ability to jointly contract with the Port Authority will allow the Turnpike Authority to take advantage of economies of scale and thus secure goods and services at lower prices.

The Turnpike Authority also proposes to update Exhibit A to N.J.A.C. 19:9, the contracting classification schedule to reflect current contracting activities and amounts.

Recognizing the desire of the contractors' associations to punish bidders who make mistakes and not to punish those who take care in the preparation of their bids, and recognizing the need to create an incentive for bidders to take the utmost care in the execution of bid documents, the Authority is adding language at the end of N.J.A.C. 19:9-2.7(g) that would prevent repeat offenders from asserting the commercially reasonable defense. Although the new language would not compel the Authority to bar a withdrawing bidder from participating in a rebid, it would give the Authority the requisite authority to punish recidivism where appropriate.

The Turnpike Authority also proposes to amend N.J.A.C. 19:9-2.9, which sets out the procedure for applying for a license to cross. A license to cross permits a third party to construct facilities (often utility-related) across Turnpike Authority property. The license is the Turnpike Authority's form of an easement, except that the rights created by the license are revocable by the Turnpike Authority. The Turnpike Authority has the responsibility to review requests for third parties to cross Turnpike Authority property to insure that the design, construction, maintenance, terms, and other concerns arising out of the proposed crossing are in the interest of the public and the Turnpike Authority. In carrying out this responsibility, the Turnpike Authority has repeatedly found it necessary to provide applicants with special instructions concerning the number of applications to be submitted and to advise them of the need for consultation with Turnpike Authority staff prior to applying for a license, and for an escrow fund in those cases where specialized engineering and legal review of the application, plans and crossing are appropriate. Thus, the Turnpike Authority proposes to amend its rules to notify all interested parties, especially their consultants and counsel, of the number of copies of each application and plan that will be required and that consultation prior to application is encouraged, that the Turnpike Authority may require an applicant to reimburse its costs of reviewing the application.

Governor James Florio recently issued Executive Order 84(1993), requiring utilization of minority and women business enterprises ("M/WBEs") in public contracts. This order applies to the Turnpike Authority's contracting activities. The Authority recently adopted a new M/WBE program and is in the process of drafting the details of the program. Once that task is completed, the Turnpike Authority expects to promulgate its M/WBE program within Subchapter 2.

Governor Florio recently issued Executive Orders 79 and 92(1993) which require modified competitive procedures for certain contract awards previously excepted from the competitive bidding process. These orders also apply to the Turnpike Authority's contracting activities. However, the Turnpike Authority is not proposing amendments to implement the new mandate inasmuch as implementing regulations are being drafted by the Department of Treasury pursuant to the terms of those orders.

Subchapter 3 sets forth the revised rates for towing to be charged by authorized towing firms to motorists whose vehicles become disabled on the Turnpike.

Subchapter 4 prescribes the Turnpike Authority's procedures for obtaining records maintained by the Turnpike Authority, including State Police accident reports. The Turnpike Authority proposes to substantially reorganize this subchapter for the convenience of citizens, the press and others seeking access to the Turnpike Authority's documents. The substantive changes found necessary and proposed to be adopted are: (i) to require payment for copies of requested documents before the copies are supplied; (ii) to specifically list those records deemed non-public under New Jersey public records case law; and (iii) to provide protocols for the review of documents. In addition, fees for State Police reports will be revised to conform with N.J.S.A. 52:2-3. Fees for copies of Turnpike Authority documents remain unchanged by the proposed amendments. A new $5.00 fee is proposed for the authentication of documents. It is also proposed to delegate to the Director of Public Affairs authority to waive copying fees and/or search charges for requesting parties that are credentialed media organizations.

Subchapter 5 describes certain miscellaneous administrative practices of the Turnpike Authority. The Turnpike Authority believes that it is necessary and reasonable to continue its practice of screening applicants for criminal backgrounds or other indicia that the applicant should not be entrusted with the responsibilities of his or her prospective job, in light of the fiscal responsibility entrusted to Turnpike Authority toll collectors, and the operational responsibility entrusted to Turnpike Authority's operations and maintenance personnel, who together make up the majority of the Turnpike Authority's 2,000 employees. Consistent with the Federal drug-free workplace policy, the Turnpike Authority proposes to add a new subparagraph to provide that applicants for employment are also subject to medical screening prior to the commencement of employment and annual medical checkups, which may include drug screening of appropriate personnel. This proposed amendment will provide notice to applicants of the procedures employed by the Turnpike Authority with respect to its prospective employees. In present practice, the Turnpike Authority conducts a routine medical evaluation of prospective employees for workers' compensation insurance purposes after an offer is made to an applicant but before employment has begun. If adopted, pre-employment drug screening may be conducted as part of the evaluation of all prospective employees, and annual drug screening may be conducted as part of the annual evaluation of Authority employees who will (i) routinely drive Turnpike Authority-owned vehicles on the Turnpike in the course of their job duties, (ii) have responsibility for the operation of the roadway or communicating with State Police patrolling the roadway and responding to emergencies, or (iii) handle significant amounts of currency as toll collectors. Finally, new provisions are proposed to codify the Turnpike Authority's ability to grant waivers from its rules, regulations and specifications and to provide a uniform procedure for requesting such waivers.

Subchapter 6 governs the procedure for petitioning the Turnpike Authority for a rule change. The Turnpike Authority finds that these rules are still necessary and reasonable, and proposes to readopt them without amendment.

Subchapter 7 sets forth the organization of the Turnpike Authority and the responsibilities of the Turnpike Authority and its various departments. The Turnpike Authority proposes to readopt this subchapter in its present format with the following changes. For the benefit of citizens and firms interacting with the Turnpike Authority, a revised organizational chart and department descriptions are proposed to reflect the new lines of authority established by the Turnpike Authority's commissioners and to reflect the most recent allocation of responsibilities for operational and administrative functions. The Turnpike Authority's responsibilities for related projects is proposed to be clarified to indicate that its responsibilities encompass not only projects related to the Turnpike, but also to any other projects that are duly authorized by law.

Social Impact

The rules proposed for readoption and the proposed amendments to the rules provide for the continued safe and efficient use, operation and administration of the New Jersey Turnpike. The rules affect all motorists

using the Turnpike as well as those individuals and firms that do business with, or are situated near, the Turnpike. Inasmuch as these rules permit the Turnpike Authority to fulfill its legislative mandate to operate a modern express highway embodying every known safety device, readoption of the rules with the proposed amendments will further the activities of individuals and businesses who rely on the Turnpike as a means of access through the State of New Jersey.

Economic Impact

The Turnpike Authority's activities have a positive economic impact upon the economy of the State of New Jersey. The current widening program and other capital projects call for the expenditure of over $1.8 billion to improve the Turnpike and other elements of the State's transportation infrastructure. Many of its contractors, suppliers and consultants are based in New Jersey or employ significant numbers of New Jersey residents, providing substantial direct and indirect benefits to New Jersey's economy. In addition, the Turnpike Authority contributes $12 million annually to the Transportation Trust Fund from toll revenues to finance other State highway projects.

The Turnpike Authority finances its operations, including the construction and maintenance of facilities, through bonded indebtedness, toll revenue and concession income as required by its enabling legislation. The Turnpike Authority meets the financial obligations created by its bonded indebtedness primarily through the collection of tolls. Because the rules further the collection of tolls and the sound operation of the roadway and minimize the operating costs of the roadway to assure repayment of the bonds, the proposed readoption with amendments will have a positive economic impact by insuring the repayment of bonds upon which many persons rely as a long-term investment device.

The proposed readoption with amendments will not affect any of the Turnpike Authority's funding sources. The fees and tolls required by these rules are intended solely to recoup the costs of such services. The fees do not constitute a source of revenue for the Turnpike Authority.

The readoption of these rules will not pose any significant economic effect on the public or other State agencies. The only rule change with the potential to increase costs to users of the Turnpike is the new cost recovery provision for cleanup of discharges. However, because the cost recovery provision merely codifies the Turnpike Authority's present ability to recoup such costs under Federal and State law, it is not expected to increase costs to businesses using the Turnpike. To the contrary, formalizing the discharge response protocol and ability to recoup costs is expected to reduce delays and legal controversies over financial responsibility for discharge cleanups, ultimately reducing the economic impact of such discharges upon motorists and motor carriers.

Further, by ensuring the safe and efficient movement of persons and goods through the State, the rules proposed for readoption will have a positive economic impact on both State and regional economies.

Regulatory Flexibility Analysis

The rules proposed to be readopted, as well as the amendments proposed herein, apply to all small businesses that use the Turnpike to transport persons and goods through New Jersey. Substantive rules regarding the control of traffic must be uniformly applied to all for the protection of the travelling public. The remaining rules are generally organizational and procedural in nature and must be applied uniformly to all segments of the business community. By maintaining a facility which enables the expedient transportation of goods and services into and through New Jersey, these rules ultimately inure to the benefit of small businesses utilizing the Turnpike.

The rules do not impose any reporting, recordkeeping or compliance requirements on small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These rules have been in effect in substantially the proposed form since the opening of the Turnpike to traffic in 1951. There has been no indication that the Turnpike Authority's rules have an adverse impact on small businesses.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 19:9.

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

19:9-1.1 Definitions

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

"Abandoned vehicles" means any vehicle whose occupants leave the vehicle unattended on the [New Jersey] Turnpike for any reason **for any period of time.**

"Authority" means the New Jersey Turnpike Authority, the body corporate and politic defined in N.J.S.A. 27:23-1 et seq., acting by and through the duly appointed commissioners thereof and their designees.

...

"Commercial vehicles" means every type of motor driven vehicle used for commercial purposes on the [New Jersey] Turnpike such as the transportation of goods, wares and merchandise, excepting such vehicle of the passenger car type.

"Construction equipment" means all vehicles, machinery and equipment enumerated in N.J.S.A. 39:4-[30]**20.**

...

"Interstate 95 Extension" means that portion of Interstate Highway 95 previously maintained by the New Jersey Department of Transportation and transferred to the Authority by N.J.S.A. 27:23-23.7, beginning at milepost 117.9+ and thence in a general northerly direction to milepost 122.0+, and all bridges, tunnels, underpasses, interchanges, entrance plazas, approaches, toll houses, service areas, service stations, service facilities, communication facilities, and administration, storage and other buildings which the Authority may deem necessary for the operation of such extension, together with all property, rights, easements and interests which may be acquired by the Authority for the construction or the operation of such extension and all other property within the Interstate 95 Extension right-of-way.

...

["New Jersey Turnpike" means any express highway, superhighway or motorway at such locations and between such termini as may hereafter be established by law, owned and/or operated under the provisions of N.J.S.A. 27:23-1 et seq. by the Authority, and shall include, but not be limited to, all bridges, tunnels, underpasses, interchanges, entrance plazas, approaches, toll houses, service areas, service stations, service facilities, communication facilities, and administration, storage and other buildings which the Authority may deem necessary for the operation of such project, together with all property, rights, easements and interests which may be acquired by the Authority for the construction or the operation of such project and all other property within Turnpike right-of-way.

"New Jersey Turnpike Authority" means the body corporate and politic defined in N.J.S.A. 27:23-1 et seq., acting by and through the official acts of the duly appointed commissioners thereof.]

"Official traffic control devices" means only those signs, signals, markings and devices approved and accepted by the [New Jersey Turnpike] Authority and placed, erected or caused to be placed or erected by [said New Jersey Turnpike] **the** Authority for the purpose of regulating, warning or guiding traffic on the [New Jersey] Turnpike.

"Omnibus" means [all motor vehicles used for the transportation of] **any motor vehicle capable of transporting 10 or more** passengers [for hire] **and registered as a bus, as indicated by the letter "O" preceding the registration number or the word "Bus" or "Omnibus" on the vehicle's license plate. Vehicles with the letters "CV" or the word "Livery" or "Autocab" on the license plate are excluded from this definition.**

...

["Sound level" means the A-weighted sound level obtained by use of fast meter response and A-weighting characteristic specified in American National Standard S1.4.1971 "Specification for Sound Level Meters" or its latest revision.]

...

"Turnpike" means any express highway, superhighway or motorway at such locations and between such termini as may hereafter be established by law, owned and/or operated under the provisions of N.J.S.A. 27:23-1 et seq. by the Authority, and shall include, but not be limited to, all bridges, tunnels, underpasses, interchanges, entrance plazas, approaches, toll houses, service areas, service stations, service facilities, communication facilities, and administration, storage and other buildings which the Authority may

deem necessary for the operation of such project, together with all property, rights, easements and interests which may be acquired by the Authority for the construction or the operation of such project and all other property within the Turnpike right-of-way.

"Turnpike right-of-way" means the area continued within the right-of-way lines as designated on [turnpike] **Turnpike** parcel property maps filed in the respective county clerk's office of each county in which the [turnpike] **Turnpike** is located.

...

19:9-1.2 Speed limits

(a) Vehicles shall not be operated on the [New Jersey] Turnpike between Interchange 14 (milepost N-0) and Interchange 14C (milepost N-8) or between the Pennsylvania-New Jersey State line on the Delaware River-Turnpike Bridge **(milepost P-0)** and the toll booths [on] **at** Interchange 6 **(milepost P-1.2)** at a speed in excess of 50 miles per hour.

(b) Vehicles shall not be operated elsewhere on the [New Jersey] Turnpike at a speed in excess of 55 miles per hour except at such locations as shall be designated for test pruposes.

(c) Where [appropriate] signs prescribing a lesser speed are posted or erected by a person or persons authorized by the [New Jersey Turnpike] Authority to post or erect such signs, no vehicle within the area or zone or section where such signs are posted or erected shall be operated in excess of the speed prescribed by said signs.

(d) [All Vehicles consistent] **Consistent** with the requirements of this section, **any vehicle operated on the Turnpike** shall **at all times** be operated at an appropriate reduced speed when specified hazards exist with respect to traffic, road, weather or other conditions **irrespective of the posted speed limit.**

(e) [Vehicles] **No vehicle** shall [not] be operated anywhere on the [New Jersey] Turnpike at a speed of less than 35 miles per hour on level ground, except where otherwise posted or when specific hazards exist with respect to traffic, road or weather conditions.

19:9-1.3 Traffic control

(a) The regulating, warning or guiding of all traffic on the [New Jersey] Turnpike shall be governed by official traffic control devices.

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

(c) All [signs, signals and markings] **official traffic control devices** on the [New Jersey] Turnpike shall be obeyed by the operators of all vehicles unless a State Police officer or authorized [New Jersey Turnpike] Authority personnel directs otherwise.

19:9-1.4 Uniform direction of traffic

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

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

19:9-1.5 "U" turns prohibited

(a) The making of a "U" turn at any point on the [New Jersey] Turnpike is prohibited.

(b) The direction of travel of any vehicle operated on the [turnpike] **Turnpike** shall be reversed only by passing through an interchange.

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

(d) (No change.)

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

(a) No vehicle[, except those listed in section 5 of this subchapter] shall be parked, stopped, loaded or unloaded or allowed to stand on the [New Jersey] Turnpike except where otherwise posted or expressly permitted by the [authority] **Authority. Excepted from the provisions of this section while in the performance of assigned duties are State Police vehicles, and the Authority's maintenance and official vehicles and vehicles authorized to furnish towing and other services to disabled vehicles on the Turnpike, and all other vehicles discharging emergency functions, such as ambulances and fire engines, when they are properly in use in the performances of authorized duties, provided that no such excepted vehicles shall be stopped so as to create a hazard to other vehicles.**

(b) (No change.)

(c) On those portions of the [turnpike] **Turnpike** where there are no shoulders, vehicles shall not be permitted to stop or stand, except in those instances where the vehicle is physically inoperable through no fault on the part of the operator or owner.

(d) (No change.)

(e) Any vehicle involved in an emergency as defined above shall be removed as promptly as possible from the [turnpike] **Turnpike.**

(f) No vehicle shall be permitted to stop or stand on any portion of the [turnpike] **Turnpike** for more than two continuous hours.

(g) [Vehicles] **Any vehicle** stopped or standing in violation of this section will be towed away at [cost of the owner] **the owner's expense.**

(h) [In addition to the foregoing provisions of this regulation] **Notwithstanding any contrary provisions of this chapter,** under no circumstances shall any vehicle be parked, stopped or allowed to stand upon the [New Jersey] Turnpike:

1.-3. (No change.)

(i) Whenever any vehicle shall be parked, stopped or allowed to stand upon the [New Jersey] Turnpike for any of the reasons [or for any of the purposes set forth in subsection (h) 1, 2 and 3 of this section] **prohibited by this chapter,** such vehicle shall be removed forthwith from the [turnpike] **Turnpike** and impounded by the Authority at the **owner's** expense [of the owner until the violation of these regulations by the operator of such vehicle shall have been determined by a court of competent jurisdiction, but in no event shall such vehicle remain impounded for a period in excess of 30 days] **until all towing and storage costs have been satisfied.**

[(j) In the event that the owner is not the operator of such vehicle and had no knowledge of the violation and had not expressly or impliedly authorized, consented to or condoned the use of the vehicle for such purposes, then, upon proof satisfactory to the authority of all of such facts and circumstances, the vehicle shall be forthwith released to the owner.]

[(k)]**(j) To insure the health, safety and welfare of motorists, the general public and the Authority,** no person shall be permitted to take photographs or motion pictures on the [New Jersey] Turnpike except as **may be** authorized by the [authority] **Authority.**

19:9-1.7 Use of medial strip prohibited

The medial strip between the traffic lanes of the [New Jersey] Turnpike shall not be used for driving upon any part thereof or for crossing between said lanes by vehicles[, subject to the exceptions contained in section 5 and section 6 of this subchapter,] or by persons on foot [unless otherwise posted]. **Excepted from the provisions of**

this section are State Police vehicles, the Authority's maintenance and official vehicles and vehicles authorized to furnish towing and other services to disabled vehicles on the Turnpike, and all other vehicles discharging emergency functions, such as ambulances and fire engines, when they are properly in use in the performance of authorized duties, provided that no excepted vehicle shall use the medial strip so as to create a hazard to other vehicles.

19:9-1.8 [Air raid precautions] **(Reserved)**

[(a) In the event of an air raid, either actual or test, no vehicles shall stop or stand on any bridge or overpass on the turnpike.

(b) Vehicles shall proceed until they are off the bridge or overpass on to the roadways of the turnpike.]

19:9-1.9 Limitations on use of [turnpike] **Turnpike**

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

1.-6. (No change.)

7. Vehicles with [deflated] **improperly inflated** pneumatic tires; also vehicles with tires in such condition that they are, in the judgment of the [employees of the New Jersey Turnpike] Authority, unsafe for use upon the [New Jersey] Turnpike;

8. (No change.)

9. Passenger vehicles [or] **and** passenger vehicle-drawn trailers carrying any load on the top or sides with lateral or horizontal projection in excess of 12 inches from body of vehicle or vertical projection in excess of 24 inches from body of vehicle[.];

10. Vehicles with metal tire or solid tire worn to metal and vehicles with caterpillar [threads] **treads;**

11. (No change.)

12. Vehicles or combinations of vehicles, including any load thereon, exceeding the following extreme overall dimensions[1] or weights:

i.-iv. (No change.)

v. Nothwithstanding the above limitations, a combination of vehicles designed, built and used to transport other motor vehicles may carry a load which [exceeds] **does not exceed** 65 feet overall length, including load overhang. The overhang shall be limited to seven feet and may not exceed three feet at the front and four feet at the rear and that the overhang shall be above the height of the average passenger car.

[1]No private utility, house-type semitrailer or trailer with a maximum length for a single vehicle of more than 35 feet, a maximum length for a semitrailer and its towing vehicle of more than 45 feet and a maximum length for a trailer and its towing vehicle of more than 50 feet shall be operated on the New Jersey Turnpike.

13. [Special permits] **Except for the Interstate 95 Extension, any vehicle operated pursuant to a special permit** issued under Title [19] **39,** [shall not be valid on the Turnpike] **unless said permit or its equivalent is issued by the Authority;**

14. Passenger vehicles or passenger vehicle-drawn trailers being towed by other vehicles[;], unless both vehicles and the connecting and control devices between them meet the following requirements[;]:

i. Not more than one vehicle [to be] **is being** towed[. Must be];

ii. A hitch bar [plus] **is used in combination with** chain strong enough to hold if **the** bar **became** disconnected **from either vehicle; and**

iii. Brakes, brake lights and directional signals on both vehicles [must be] **are** controlled by **the** driver of towing vehicle and synchronized. [Trailers] **A trailer** with **a** gross weight of 3,000 pounds or less may [have no] **be operated without** brakes if **it is** towed by **a** vehicle **whose gross weight is at least** 2½ times **the** gross weight of **the** trailer[.];

15. Vehicles with loads extending more than four feet:

i. Beyond the rear of the **vehicle** body or other supporting member; **or**

ii. Beyond the rear of vehicle-drawn trailer;

16. (No change.)

17. Vehicles so loaded or operated that the contents or any part thereof may be scattered on the [turnpike] **Turnpike** roadway;

18. Vehicles [which] **that** are not capable of maintaining a speed of at least 35 miles per hour on a level grade;

19. Vehicles not otherwise specified in this section [in such condition as to] **that** create a probable hazard to other vehicles or to persons;

20. [House] **During winds or during the prevalence of other adverse weather conditions, house** trailers, horse trailers, boat trailers, utility trailers, **motorcycles** and all passenger vehicle-drawn trailers [during winds or during the prevalence of other adverse weather conditions];

21. Vehicles in tow:

i. With an axle or combination of axles[,] raised off the ground and supported by cable, chains, rope, **dollies** or other devices;

ii. Without axles raised [and], **if** interconnected with rope, chains, cable or pipe[. Tow] **or tow** bars without chains; **or**

iii. By a fifth wheel crane or hoist mounted on a truck-tractor.

22. Vehicles owned or operated by [members] **a member or employee** of a diplomatic mission [who are included in the most current Diplomatic List published by the Department of State of the United States of America; or vehicles operated by employees of said diplomatic mission who are included in the most current list of Employees of Diplomatic Missions published by the Department of State of the United States of America; in those instances where members or employees], **where said member or employee** of the diplomatic mission [have received a] **has been sent** prior written notice from the [authority] **Authority** that said [members and/or employees of the diplomatic mission had] **member or employee** violated **any provision of** N.J.A.C. 19:9[-1.2] and who, subsequent to said notice, [had] again violated [the aforementioned] **a provision of** N.J.A.C. 19:9[-1.2]. Upon occurrence of the second violation, said vehicle or vehicles shall be escorted off the [turnpike] **Turnpike** at the nearest point of exit or interchange;

23. (No change.)

24. Three-vehicle [combination] **combinations,** commonly known as "Double Saddlemount," wherein a tractor is hauling two additional tractors[.]; **and**

25. [Autobuses] **Omnibuses** exceeding [61] **40** feet [and zero inches] in length, **excluding bumpers, and articulated omnibuses exceeding 61 feet in length,** excluding bumpers. [Notwithstanding any other provision contained herein, an autobus, for the purpose of this regulation, is defined as an articulated motor vehicle used for the transportation of passengers for hire, not including school buses, which has a length in excess of 40 feet, but less than 61 feet and one inch, excluding bumpers.]

(b) [Employees of the New Jersey Turnpike] **In addition to the State Police, toll collection employees of the** Authority [in charge of toll booths] are authorized to enforce the provisions of this section, and all persons shall comply with the orders of such employees given to prevent the use of the [turnpike for] **Turnpike by** any of the aforesaid [forbidden purposes] **prohibited vehicles.**

19:9-1.10 Waste and rubbish

(a) Littering of the [New Jersey] Turnpike with bottles, cans, papers, garbage or rubbish including tobacco and tobacco products or other materials of any kind or description is prohibited.

(b) The throwing or discarding of any such material from [turnpike] **Turnpike** structures is also prohibited.

19:9-1.11 Loose cargo; **discharges**

(a) [Commercial vehicles] **Vehicles** carrying material **likely to spill that is** not otherwise boxed, crated, bagged or packaged [and inclined to spill, must have the load completely covered by] **must be firmly secured on all sides with** a tarpaulin **completely covering the material,** [firmly secured on all sides] **and capable of preventing the escape of said material.**

(b) No material, whether solid, liquid or gaseous, shall be discharged on Turnpike property, whether intentionally or unintentionally. This prohibition shall apply to any material being carried as cargo, whether or not for hire, and to any material that is a part of the vehicle or necessary for the operation of the vehicle or any

apparatus affixed thereon, but shall not apply to ordinary vehicular emissions anticipated by the original design of the vehicle or the apparatus affixed thereto.

19:9-1.12 Damaging of [turnpike] **Turnpike** property

(a) No person shall cut, mutilate or remove any trees, shrubs or plants located on the [New Jersey] Turnpike.

(b) No person shall deface, damage, mutilate or remove any [sign] **official traffic control device**, delineator, structure, fence or other property or equipment of the [New Jersey Turnpike] Authority or its concessionaires.

(c) No person shall install or attempt to install, construct or place upon any portion of the [New Jersey] Turnpike, any item, sign, structure or equipment for any purpose whatsoever, without prior written approval of the [authority] **Authority.**

(d) No material shall be discharged on Turnpike property, whether intentionally or unintentionally, that may cause damage to the Turnpike, the general public, the Authority, its agents and employees, or any real or personal property owned, leased or under the supervision of the Authority. For purposes of this subsection only, "damage" includes any effect which may be injurious to health, safety or welfare, or which may cause financial loss or delay the movement of traffic.

(e) The operator, owner or lessee of any vehicle from which a discharge in violation of any provision of this section or N.J.A.C. 19:9-1.10, 1.11(b) or 1.15 occurs, regardless of the cause of the discharge, shall cooperate fully with the Authority, its employees, agents, and third parties authorized to respond to an emergency, discharge or blockage of traffic by the Authority, the State Police and the Department of Environmental Protection and Energy and shall take any action deemed necessary by them to restore normal traffic conditions and to remove spilled or otherwise discharged material from the Turnpike immediately. The vehicle operated, owned or leased by any person failing to cooperate or take such action as deemed necessary by the official in charge of the scene where the discharge occurred is subject to impoundment by the Authority, the State Police, or the New Jersey Department of Transportation and their agents and employees until such time as all penalties, towing and storage fees and costs have been satisfied.

(f) In addition to any penalties prescribed by this chapter or by the laws and regulations of other government entities including, but not limited to, Titles 2C, 13, 27, 39 and 58 of the New Jersey Statutes and Federal law or regulation, any person violating any provision of this section or N.J.A.C. 19:9-1.10, 1.11(b) or 1.15, shall be liable to the Authority for any and all costs arising out of said violation, including the costs of:

1. Collecting, testing and disposing of the material and restoring the Turnpike to its condition immediately prior to the violation;

2. Replacing or repairing, in the Authority's sole discretion, any property damaged by reason of said violation;

3. Toll and concession revenue lost because of the closing of the Turnpike, any part thereof, or any interchange by reason of said violation;

4. Medical care, supervision or other costs relating to personal injury suffered by the general public, the Authority, its agents or employees; and

5. Any other costs arising out of said violation and incurred by the Authority or third parties.

(g) The Authority may recover the costs under (f) above by way of complaint filed in Superior Court, Law Division or United States District Court, by an administrative consent order executed by an authorized representative of the Department of Environmental Protection and Energy, or by any other lawful means.

19:9-1.13 Hitch-hiking, loitering, soliciting, and distributing prohibited

The soliciting of rides commonly known as "hitch-hiking" at or near [the] toll booths, **service areas,** and [on] all other portions of the [New Jersey] Turnpike is prohibited. Loitering, soliciting funds or services, selling [of] goods, distributing pamphlets and literature in or about the toll booths, service areas and all other portions of the [New Jersey] Turnpike is prohibited.

19:9-1.14 Repairs and towing

(a) Subject to the provisions of N.J.A.C. 19:9-1.6, a vehicle [which] **that** becomes disabled while using the [New Jersey] Turnpike may be repaired by the occupants thereof [providing], **provided that** the occupants can complete repairs within a two-hour period from the time of disablement and **the** occupants do not leave **the** vehicle unattended. A vehicle disabled and abandoned by its occupants will be removed immediately by an authorized service of the [New Jersey Turnpike] Authority at the expense of the owner.

(b) If other mechanical services or towing is required, such services or towing must be performed by a service agency authorized by the [New Jersey Turnpike] Authority to furnish such service on the [turnpike] **Turnpike.**

(c) If towed, such disabled vehicles must be removed at the nearest exit [way] in the original direction of travel.

(d) A truck or bus company may obtain a private mechanical and towing service permit provided they conform to the rules and regulations governing said permits. [(Applications and rules and regulations may be obtained from the Office of the Director of Operations.)]

(e) A truck or bus company may obtain a permit to perform their own tire service or designate a prearranged tire service[. Said]; **said** permits **are** obtainable from the Office of the Director of Operations. Truck or bus companies not holding a private tire service permit [will] **may either** receive tire service from a service agency authorized by the [New Jersey Turnpike] Authority [to furnish such] **or be removed by a towing** service [on] **authorized** by the [turnpike] **Authority.**

19:9-1.15 Transportation of hazardous materials

(a) The transportation or shipment [upon] **on** the [New Jersey] Turnpike of any hazardous materials, as defined in [part] **Part** 172 of the [Regulations] **regulations** of the United States Department of Transportation (49 CFR 172), shall be subject to the requirements of parts 171 to 178 inclusive of such [Regulations] **regulations** (49 CFR 171 to 178) governing the preparation of the materials for transportation, construction of containers, packing, weighing, marking, labeling, billing and certification of such materials.

(b) The transportation or shipment [upon] **on** the [New Jersey] Turnpike of radioactive materials or devices, and transportation of Class A, B and C explosives, as defined in [part] **Part** 173 of the [Regulations] **regulations** of the United States Department of Transportation (49 CFR 173), shall be subject to the prior written approval of the [New Jersey Turnpike] Authority. All applications for such approval shall be made in writing[,] addressed to the Director of Operations and shall provide, to the satisfaction of the Authority, that the shipment shall comply in all respects with the provisions of parts 171 to 178 and 397 inclusive of the Regulations (49 CFR 171-178, 397).

(c) The Authority reserves the right to withhold the approval required in (b) above, and to prohibit entry to the [turnpike] **Turnpike** of any carrier of any hazardous materials, despite compliance with the aforementioned [Regulations] **regulations** of the United States Department of Transportation or any other pertinent regulations or law, if in [its] **the Authority's** opinion, the transportation or shipment will be likely to endanger life or property.

(d) (No change.)

(e) Any operator, owner or lessee of a vehicle on the Turnpike which contains any hazardous material shall be subject to all provisions and penalties hereunder, in addition to any provisions of the United States Code, the New Jersey Statutes and the New Jersey Administrative Code.

(f) In the event of a discharge of hazardous materials on the Turnpike, all remedial efforts shall be conducted in compliance with these rules and under the supervision of the Authority, the State Police, and/or the Department of Environmental Protection and Energy.

1. Where practicable, not contrary to the rules of the Department of Environmental Protection and Energy, and not contrary to the safety of the operator, the general public, or the Turnpike, the

operator, owner or lessee of the vehicle may be afforded the opportunity to contain and remove discharged material using personnel, materials and equipment provided:

i. Aboard the vehicle from which the discharge occurred;

ii. By another vehicle owned or leased by the operator, owner or lessee of the vehicle from which the discharge occurred;

iii. By a specialized response team operated by the manufacturer or distributor of the hazardous material that has been discharged (hereafter, "manufacturers' response team"); or

iv. By third parties contracted to contain, clean up, and/or dispose of the discharge (hereafter, "emergency response contractors") by the operator, owner or lessee of the vehicle specifically for the purpose of remediating hazardous materials discharges from the operator's vehicle.

2. No emergency response services may be provided pursuant to (f)1ii through iv above unless all the entities undertaking such services have provided to the Authority proof of adequate insurance and such other information as may be required by the Director of Operations.

3. The Authority shall make available to any operator, owner or lessee so requesting a list of emergency response contractors that have met the requirements of (f)2 above to perform emergency response services on the Turnpike. The operator, owner or lessee shall arrange and pay for emergency response services to be performed by such contractors. Approval of such contractors pursuant to (f)2 above is not to be considered a warranty or assurance by the Authority of such contractors' ability to perform emergency response services.

4. Whenever the operator, owner or lessee refuses to arrange for an emergency response contractor, or whenever exigent circumstances or the risk posed by the discharge to Turnpike patrons, the general public, or the Authority's agents or employees is too great to await the arrival of the emergency response contractor(s) arranged by the operator, owner or lessee in the opinion of the Director of Operations or the Director's designee, the Director or the Director's designee may arrange for emergency response services and long-term remedial efforts to be provided by a third party of the Authority's choice. Emergency response and long term remedial services may be performed by or through the Department of Environmental Protection and Energy or its agents, including any county environmental health department, or by private organizations engaged by the Authority. The cost of services pursuant to this paragraph shall be based on the most recent agreement between the Authority and the third party, or if there is no such agreement, shall be based on the schedule of rates normally charged to commercial concerns for emergency response or long-term remedial services, and shall be borne by the operator, owner or lessee of the vehicle.

i. If, at the time the emergency response contractor arrives at the scene of the discharge, the operator, owner or lessee of the vehicle refuses to agree to pay or complete any documents necessary to engage the contractor for such services, the Authority may impound the vehicle and any cargo or contents thereof until such time as the costs of remedial services are satisfied. If such costs are not satisfied within 14 days, the Authority shall have the right to sell the vehicle, its cargo and contents at public auction and/or to recover any unsatisfied costs by filing a civil action in the Superior Court of New Jersey or in any District Court of the United States having jurisdiction over such action.

ii. If the emergency response contractor refuses to contract with the operator, owner or lessee of the vehicle because of a bona fide concern about the operator's, owner's or lessee's ability or willingness to pay for such services, the Director or the Director's designee may authorize such services to be performed at the Authority's expense, and the Authority may thereafter recover the costs thereof from the operator, owner or lessee by filing a civil action in Superior Court of New Jersey or in any District Court of the United States having jurisdiction over such action. The emergency response contractor's concern shall be deemed bona fide if the operator's, owner's or lessee's credit record indicates a history of refusal or failure to pay commercial debts.

19:9-1.16 Intoxicating beverages

No person shall consume or imbibe any intoxicating beverage from a bottle or container[,] containing liquor, beer, wine or other alcoholic beverage[,] while operating a vehicle on the [New Jersey] Turnpike.

19:9-1.17 Operation[s] of vehicles on [turnpike] **Turnpike** projects[:]; care required

No vehicle shall be operated carelessly, without due caution or prudence, or in a manner so as to endanger [persons] **any person** or property, or while the operator is under the influence of intoxicating liquors or any narcotic or habit-forming drug.

19:9-1.18 Noise limits

(a) No vehicle shall be operated [or permitted to operate on the New Jersey Turnpike at any time or under any condition of highway grade, load, acceleration or deceleration in such manner as to generate a sound level in excess of the maximum sound levels specified in table 1 for the category of vehicle and posted speed when measured at a distance of 50 feet from the center of the lane of travel, and at other distances in accordance with the table of distance adjustment factors specified in table 2. Measurements shall be made in accordance with the procedures and the measuring device specifications adopted by the authority. Sound level limits are based on the use of A-weighting and fast meter response.] **on the Turnpike in violation of 49 C.F.R. 325 or any other noise standards promulgated by the United States or the State of New Jersey and applicable to that class of vehicle.**

[Table 1. Maximum sound levels

Type of vehicle	Posted speed limit or posted advisory speed: 35 mph or less	over 35 mph
Any vehicle having six or more tires, or any vehicle having a G.V.W.R. or G.C.W.R. in excess of 10,000 lbs.		
After January 1, 1975	86 dB(A) 45 mph or less	90 dB(A) over 45 mph
After January 1, 1978	80 dB(A)	84 dB(A)
After January 1, 1990	75 dB(A)	78 dB(A)
Any vehicle with four tires or a G.V.W.R. of less than 10,000 lbs.	35 mph or less	over 35 mph
After January 1, 1978	70 dB(A)	79 dB(A)
Any motorcycle		
After January 1, 1978	78 dB(A)	82 dB(A)
After January 1, 1990	75 dB(A)	78 dB(A)

Table 2. Distance adjustment factors

Distance more than—	Adjustment to Limit, dB(A)
35 ft. but not more than 39 ft.	+3
39 ft. but not more than 43 ft.	+2
43 ft. but not more than 48 ft.	+1
48 ft. but not more than 58 ft.	0
58 ft. but not more than 70 ft.	-1
70 ft. but not more than 83 ft.	-2

Note: This section applies to the total noise from a vehicle or combination of vehicles and shall not be construed as limiting or precluding the enforcement of any other provisions of these regulations.

(b) No vehicle powered by an engine with an engine speed governor shall be operated or permitted to be operated on the New Jersey Turnpike if such vehicle generates a sound level in excess of the maximum sound level specified in this section when that engine is accelerated with wide-open throttle, from idle to governed speed with the vehicle stationary, transmission in neutral and clutch engaged.

Distance from longitudinal
center line of vehicle: 50 feet
Maximum sound level: 88 db(A)

When measurements are made at a distance other than 50 feet, the maximum sound level shall be adjusted by the distance correction factor specified in table 2 of this section. Measurements shall be made in accordance with the procedures and measuring device specifications adopted by the authority. Sound level limits are based on the use of A-weighting and fast meter response.]

[(c)](b) No vehicle shall be operated on the [New Jersey] Turnpike whose exhaust system is:

1.-3. (No change.)

[(d) No vehicle shall be operated on the New Jersey Turnpike with tires having a tread pattern that, as originally manufactured or newly retreaded, is composed primarily of cavities in the tread surface (excluding sipes) that are not vented by grooves to the tire shoulder or circumferencially to each other around the tire. This requirement shall not apply to any vehicle if such vehicle can be shown to comply with the noise emission limits of (a) above.]

19:9-1.19 Tolls; payment required

No vehicle shall be operated on the [New Jersey] Turnpike except upon the payment of such tolls as are required by the [New Jersey Turnpike] Authority.

19:9-1.20 Records

(a) [Every person driving any] **Any operator of** a commercial motor vehicle, omnibus, motor bus, or tractor in interstate commerce upon the [New Jersey] Turnpike shall keep records showing the day and hour when, and the place where, [he] **the operator** went on and was released from duty, whether in or outside of this State[, and in case such driver]. **In the event the operator** went on duty at a place outside of this State, [he] **the operator** shall, immediately upon entering the [New Jersey] Turnpike, certify upon such records that they are correct.

(b) Records showing the day and hour when, and the place where the [driver] **operator** went on **duty** and was released from duty are not needed, provided:

1. The [driver] **operator** does not operate beyond the 100-mile radius of the work reporting location more than one time in any seven consecutive day period;

2. The [driver] **operator**, except a driver salesperson, returns to the work reporting location within 12 hours;

3. At least eight consecutive hours off-duty separate each 12 hours on duty; and

4. The motor carrier which employs the [driver] **operator** maintains accurate and true records showing:

i. The total number of hours the [driver] **operator** is on duty each day;

ii. The time the [driver] **operator** reports for duty each day;

iii. The time the [driver] **operator** is released from duty each day; and

iv. The total on-duty time for the preceding seven days for [drivers] **operators** used for the first time or intermittently.

19:9-1.21 Other regulations

In addition to these traffic rules, users of the Turnpike are subject to all applicable statutory provisions, including, but not limited to, penalties for nonpayment of tolls (N.J.S.A. 27:23-25), penalties for violation of any of the Authority's regulations (N.J.S.A. 27:23-32), United States Department of Transportation regulations, and, except as otherwise provided hereinabove, the Motor Vehicle and Traffic Acts of New Jersey relating to lights, brakes, weights, registration and other matters (N.J.S.A. 39:3-1 et seq. and 39:4-1 et seq.). Commercial vehicles in interstate commerce using the Turnpike remain subject to Interstate Commerce Commission regulations.

[Note: In addition to these traffic regulations, users of the New Jersey Turnpike are subject to applicable statutory provisions, including among other things penalties for nonpayment of tolls (N.J.S.A. 27:23-25), penalties for violations of the regulations (N.J.S.A. 27:23-32) and, except as otherwise provided hereinabove, the Motor Vehicle and Traffic Acts of New Jersey relating to lights, brakes, weights, registration and other matters (N.J.S.A. 39:3-1 et seq., 39:4-1et seq.); also Interstate Commerce Commission regulations as to commercial vehicles in interstate commerce.]

19:9-2.2 Purchases for amounts requiring public advertising

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

(c) Rules concerning receipt, opening, and award of bids:

1.-4. (No change.)

5. Correction or withdrawal of inadvertently erroneous bids after opening, or cancellation of awards or contracts based on such mistakes, may be permitted in the sole discretion and determination of the Authority. After bid opening, no changes in bid prices or other provisions of bids prejudicial to the interest of the Authority or fair competition shall be permitted and a decision to permit the correction or withdrawal of bids, or to cancel awards or contracts, based on bid mistakes, shall be supported by a written determination made by the [director of Purchasing] **Director of Administrative Services and Technology** or the Chief Engineer.

6. (No change.)

7. When it is determined impractical to initially prepare a purchase description to support an award based on price, an Invitation for Bids or Advertisement for Proposals may be issued requesting the submission of unpriced proposals to be followed by an Invitation for Bids or Advertisement for Proposals limited to those bidders whose unpriced proposals have been determined as qualified for the project by the Director of [Purchasing] **Administrative Services and Technology** or the Chief Engineer.

8. Bid or proposal guarantees or bid or proposal bonds may be required [as part of any bid in the discretion of] **in such form and amount as deemed necessary** by the Director of [Purchasing] **Administrative Services and Technology** or Chief Engineer **to insure faithful performance of the contract or for the payment of persons performing work on the project**. In that event, the requirement of a bid or proposal guarantee or bond, **and the form and amount thereof** shall be set forth or specified in the bid specifications.

9. Performance bonds [or], contract bonds **or consents of surety** may be required in [the discretion of] **such form and amount as deemed necessary** by the Director of [Purchasing] **Administrative Services and Technology** or Chief Engineer to insure faithful performance of the contract or for the payment of persons performing work on the project. In that event, the requirement of a performance or contract bond **or consent of surety, and the form and amount thereof** shall be set forth or specified in the bid specifications. The bond shall be submitted by the successful bidder upon notification.

(d) Rules concerning dispensing with public bid procedure:

1. A contract may be awarded for a supply, service, or product without competitive sealed proposals when the Authority upon written recommendation of the Director of [Purchasing] **Administrative Services and Technology** or the Chief Engineer determines and acts by appropriate resolution that there is only one source for the required supply, service or product.

2. When the Authority deems that there exists threat to the health, welfare or safety of the public or of property under emergency conditions, or the exigency of the situation does not allow sufficient time to advertise and award bids by public bidding, the Authority may, by appropriate resolution, acting on the written recommendation of Director of [Purchasing] **Administrative Services and Technology** or Chief Engineer, waive the requirement of public bidding provided that such emergency requirements shall be made with such competition as is practicable under the circumstances.

19:9-2.3 Purchases under amount requiring public advertising

(a) In the case of purchases of personal property or services, where the aggregate cost or amount involved is less than the minimum amount for which public advertising for bids is required, competitive bidding is not required. As determined in the discretion of the Director of [Purchasing] **Administrative Services and Technology** or Chief Engineer, price quotations may be solicited from ven-

dors to the extent determined appropriate by the Director of [Purchasing] **Administrative Services and Technology** or Chief Engineer.

(b) Awards of bids may be to other than the lowest bidder for valid reasons, if specifically recommended by the Director of [Purchasing] **Administrative Services and Technology** or Chief Engineer.

19:9-2.4 Termination of contract

A contract awarded to the successful bidder may be terminated by the Authority at any time for inadequate or improper performance, or for breach of any terms, conditions, or obligations of the contract, as determined by the Authority, or if the vendor shall make an assignment for the benefit of creditors, or file a voluntary petition in bankruptcy, or if an involuntary petition in bankruptcy is filed against the vendor and the act of bankruptcy therein alleged is not denied by the vendor and the act of bankruptcy therein alleged is not denied by the vendor. Upon termination, the Authority shall be liable only for payment of goods or services properly performed in accordance with the contract. The Authority shall have the right to purchase non-delivered goods to replace defective goods and services on the open market and hold the vendor liable for the difference between the price set forth in the contract for such goods or services and the prices paid on the open market. Further, the Authority reserves the right to terminate any contract entered into provided written notice has been given to the contractor at least [(15)] **15** days prior to such proposed termination date. In addition, the Authority shall have the right, without the necessity of court proceedings, to recover all equipment, material or supplies that are the property of the Authority and have been entrusted with the vendor to be used in the performance of said contract. Nothing in this section is intended to limit the Authority's right to legally pursue all costs which exceed the amount due and [owning] **owing** the vendor under said contract. The list of remedies in this section is not exclusive.

19:9-2.5 Purchases under or in combination with State or other agency contracts

(a) When it is determined to be proper and in the best interest of the Authority, the Authority may purchase equipment, goods, materials and supplies directly, without advertising, from vendors who hold contracts with the State of New Jersey or other State **or multi-state** authorities or agencies.

(b) When it is determined to be proper and in the best interests of the Authority, the Authority may contract with and purchase by public bid procedure, services, equipment, goods, materials and supplies, in combination with the requirements of the State of New Jersey or other State **or multi-state** authorities or agencies.

(c) In either event, the Director of [Purchasing of] **Administrative Services and Technology** or Chief Engineer will submit a written recommendation to the Authority which shall set forth the details of the proposed acquisition and shall state the reasons for proceeding under or in combination with such State or other State authority contract or requirements.

19:9-2.6 Sale of surplus personal property

(a) Sales of surplus personal property, where the anticipated aggregate proceeds are estimated by the Director of [Purchasing] **Administrative Services and Technology** or exceed the minimum amount requiring public advertising of purchases, shall be made after public advertisement and competitive bids. The advertising and bid procedures shall be basically as set forth in N.J.A.C. 19:9-2.2(a), (b) and (c). The Authority may by resolution waive the requirement of public advertising on a particular sale.

(b) In the case of sales of surplus personal property, where the anticipated aggregate proceeds are estimated by the Director of [Purchasing] **Administrative Services and Technology** to be less than the minimum amount requiring public advertising or purchases, competitive bidding is not required. As determined in the discretion of the Director of [Purchasing] **Administrative Services and Technology**, price quotations may be solicited from vendors to the extent determined appropriate by the Director of [Purchasing] **Administrative Services and Technology.**

(c) (No change.)

(d) In the event no bids, or inadequate or low bids, in the determination of the Director of [Purchasing] **Administrative Services and Technology,** are received, the Director of [Purchasing] **Administrative Services and Technology** may in his discretion reject all bids, reoffer for sale, negotiate, trade-in or scrap the sale items.

(e) Upon determination by the Director of [Purchasing] **Administrative Services and Technology**, surplus personal property or equipment may be sold in conjunction with or as part of an auction or sale proceeding conducted by the State of New Jersey or other State authorities.

19:9-2.7 Procedure for prequalification[s] and award of construction contracts

(a) All prospective bidders for construction in excess or $50,000 shall be prequalified annually into classifications by the Chief Engineer. Prospective bidders will be classified according to the type of work and the amount of work on which they are entitled to bid as set out in **the schedule of classifications set forth at** [Exhibit] **Appendix A to this chapter, incorporated herein by reference** [(See end of Chapter 9)]. Proposals submitted by prequalified bidders who have received classification ratings **as** set forth in [Exhibit] **Appendix A within 10 percent of the total price of the proposal** will be considered for award by the Authority [when the total price of the proposal exceeds the maximum limit of the rating by 10 percent or less]. The Chief Engineer may, from time to time, add additional specialized work categories to [Item 24 "Special Classification."] **the schedule of classifications.**

(b) In order to prequalify in classification, prospective bidders shall submit annually or at least 21 calendar days prior to bid opening of a specific contract, [the] proof of the following:

1. As to type of work, recent satisfactory experience as a contractor on a contract involving substantially the same or similar work to the classification being sought[.];

2. As to amount of work, recent satisfactory experience as a contractor on a single contract having a value of at least 60 percent of the maximum limit of the classification rating being sought; or[,] several contracts performed at or about the same time having a cumulative value of at least 60 percent of the said maximum limit[.];

3. Satisfactory financial condition of the prospective bidder[.];

4. Adequate facilities, including plant, equipment and experience of key personnel and officers of the [company] **prospective bidder;**

5. [Affidavit that] **That** the bidder is not now, nor has been involved, directly or indirectly, in any proceeding, conduct or activity relating to, or reflecting upon, the moral integrity of the bidder[.] **by means of sworn affidavit; and**

6. A Contractor's Qualifying Statement[: The statement shall show] **showing** the prospective bidder's status at the end of the month prior to the date of the statement. [Prequalified] **When submitting a proposal, prequalified** bidders [shall] **may** not submit another Qualifying Statement [when submitting proposal,] but will **instead** submit a prequalification recapitulation [when submitting proposals] **in such form as may be prescribed by the Authority.**

(c) The Chief Engineer shall review the statement and other information submitted by the prospective [bidders] **bidder** and shall notify [them of his] **the prospective bidder of the** decision as to their classification by certified mail. The classification will be valid for a period of one year from the date of the Chief Engineer's decision, and the prospective bidder will be allowed to bid on all [Turnpike] **Authority** contracts within its classification limits for this one year period without the need of additional prequalification, subject to subsections (d) and (g) below. At the end of this one year period, the prequalification of the bidder will expire, and to be renewed, the prospective bidder must meet the requirement of [subsection] (b) above.

(d) The Chief Engineer shall reserve the right to require a **prospective** bidder to submit such additional evidence of [his] qualifications as [he may deem] **deemed** necessary, and shall consider any evidence available [to him] of the financial, technical, and other qualifications and ability of [a] **the** bidder. The Chief Engineer may

change or revoke at any time the classifications of any bidder upon any evidence that said bidder does not meet the financial, technical, moral or other qualfications of the classification.

(e)-(f) (No change.)

(g) A bidder may be disqualified from future bidding on any [Turnpike] **Authority** project if such bidder claims, whether successfully or not, its right to withdraw its bid because of a unilateral mistake. Such qualification may be effective for a period of **up to** six months from the date of opening the bid sought to be withdrawn. Only in cases where the withdrawing bidder did not act in a commercially reasonable manner would the Authority choose to disqualify the bidder, **unless the bidder previously sought to withdraw a bid within the 12 months preceding the date of opening of the bid sought to be withdrawn, in which event the bidder may be disqualified regardless of whether the second mistake was commercially reasonable.**

(h) (No change.)

19:9-2.8 Procedure to resolve protested solicitations and awards

(a) Any actual or prospective bidder, offeror or contractor who is aggrieved in connection with the solicititation or award of a contract or its prequalification status or classification may protest to the Authority. The protest shall be submitted in writing within five **business** days after such aggrieved person knows or should have known of the facts giving rise thereto. Failure to file a timely protest shall bar any further action. The written protest shall set forth in detail the facts upon which the protestant bases its protest.

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

(e) In the event of a timely protest under [subsection] (a) above, the Authority shall not proceed further with the solicitation, or with the award of the contract until the decision is rendered under subsection (c) above, or until the Executive Director after consultation with the Director of [Purchasing] **Administrative Services and Technology** or Chief Engineer makes a written determination that the continued solicitation or award of the contract without delay is necessary to protect the interests of the Authority or the public.

19:9-2.9 Licenses to cross

(a) A license to cross is a formal agreement with the [New Jersey Turnpike] Authority granting permission to cross and/or access any Turnpike property of any nature or description. This normally pertains to public and private utilities which must cross the [New Jersey] Turnpike roadway in order to provide service to the public. In addition, licenses to cross are utilized by adjacent property owners to the [New Jersey] Turnpike roadway that must utilize the [New Jersey] Turnpike property for drainage and access purposes. **Before seeking a license to cross, applicants are strongly advised to first consult with the Authority's Director of Law to ascertain what information will be required as part of the application and to meet with representatives of appropriate departments of the Authority. Said consultation may be arranged in the discretion of the Director of Law upon the applicant's request.**

(b) In order to apply for a license to cross, **an original and 11 copies of** a letter containing the location of the Turnpike property affected, the purpose of the crossing and **such other information as may be required by the Authority, along with 12 copies of** the engineering plans **in such form as may be required by the Authority** shall be submitted to:

[Herbert I. Olarsch,] Director of Law
New Jersey Turnpike Authority
P.O. Box 1121
New Brunswick, New Jersey 08903

(c) A license to cross shall be evaluated based on the following:

1. Adherence to the New Jersey Turnpike Authority Standard Specifications, **as amended and supplemented**;

2.-6. (No change.)

7. The effect of the proposed crossing on the financial, economic or engineering aspects of the activities of the [New Jersey Turnpike] Authority, the public or neighboring property, owners.

(d) Competing applications will be assessed based upon (a) through (c) above. The award will be based on the application which most closely serves the needs of the [New Jersey Turnpike] Authority and the public.

(e) (No change.)

19:9-2.10 Procedure to resolve protested applications for, and awards of, licenses to cross

(a) Any actual or prospective applicant for a license to cross on any [Turnpike] Authority property or facility[,] who is aggrieved in connection with the application for and/or award of such a license, may protest to the [Turnpike] Authority. The protest shall be submitted in writing to the Director of Law within [10] **five business** days after such aggrieved party knows or should have known of the facts giving rise to the grievance. Failure to file a timely protest shall bar any further action. The written protest shall set forth in detail the facts upon which the [protestant] **aggrieved applicant** bases its protest and shall define, as clearly as the available information permits, those issues or facts in [contest] **dispute**.

(b) (No change.)

(c) If the protest is not resolved by mutual agreement, the Executive Directors shall promptly issue [his or her] **a** decision in writing. The Executive Director's decision shall state the determination made and the reasons for the action taken. The Executive Director's decision shall be mailed or furnished promptly to the [protestant] **aggrieved applicant** and any other interested party. The members of the Authority shall review the decision of the Executive Director and shall adopt, review or modify the decision of the Executive Director [no later than] **within** 45 days of [such] **said** decision [of the Executive Director].

(d) (No change.)

(e) In the event of a timely protest under (a) above, the Authority shall not proceed further with the application for, or with the award of, [a] **the** license to cross in issue until the decision is rendered pursuant to (c) above.

19:9-3.1 Towing rates

(a) [The towing rates are as follows] **Towing rates charged by Authority-authorized companies shall conform to the following rates or such rates as may be approved and amended by the Commissioners from time to time, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the rules on agency rulemaking, N.J.A.C. 1:30.**

1. Class 1 vehicles (24 hours):

i. Service charge, [$25.00] **$40.00 or $50.00 for flatbed; plus**

ii. [$1.50] $2.00 per mile on [turnpike] **Turnpike** to a maximum of [$40.00] **$60.00 or $70.00 for flatbed plus;**

iii. Additional charge of $5.00 for the use of dolly wheels;

iv. An additional charge of $15.00 for disconnecting a drive shaft;

v. An additional charge of $30.00 for removing a chrome bumper; and

vi. An additional charge of $20.00 for removing an axle.

2. Class 2-6 vehicles:

i. Service charge, [$45.00] **$70.00 for straight truck, car with trailer, or trailer without car of $100.00 for tractor trailer or bus;**

ii. [$2.50] **$3.00** per mile on [turnpike (maximum of 10 miles)] Turnpike to a maximum of [$70.00] **$100.00 for straight truck, car with trailer, or trailer without car or $5.00 per mile for tractor trailer or bus to a maximum of $150.00;** plus

iii. An additional charge of [$10.00] **$15.00** for connecting air lines [or removing axles]; [and]

iv. An additional charge of $15.00 for disconnecting drive shaft **on cars and small trucks or $30.00 on large trucks** [or removing chrome bumper.];

v. An additional charge of $30.00 for removing a chrome bumper;

vi. Additional charge of $20.00 for removing an axle; and

vii. Additional charge of $45.00 for removing an air scoop.

3. Winching and wrecking (all classes of vehicles):

i. [$30.00] **$50.00** per hour for **a** light wrecker;

ii. [60.00] **$100.00** per hour for a heavy wrecker; [and]

iii. [$150.00] **$350.00** per hour, **two hour minimum** for **construction-type** cranes in excess of [50,000] **40,000** pounds[.] **and**

iv. $225.00 per hour, two hour minimum for specialized equipment, including heavy duty underreach, Landoll Hydraulic Trailer,

40 to 45 ton Challenger, Oshkosh, Sterling-type wrecker crane, box trailer with tractor and driver or wrecker with wheel lift.

19:9-3.2 Road service rates

(a) Road service rates for Class 1 vehicles charged by Authority-authorized service companies shall conform with the following rates or such rates as may be approved and amended by the Commissioners from time to time, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and the rules on agency rulemaking, N.J.A.C. 1:30.

1. Road service charge: $30.00;

2. Gasoline/diesel: Cost of product plus road service charge;

3. Tire change: Road service charge;

4. Tire repair/replacement: Cost of product plus road service charge;

5. Battery service: Road service charge; and

6. Water: Road service charge.

19:9-3.3 Questions and disputes

Questions and disputes concerning the rates or quality of towing or road service provided by Authority-authorized companies may be directed to the Director of Operations.

SUBCHAPTER 4. INSPECTION AND OBTAINING OF [TURNPIKE] AUTHORITY RECORDS

19:9-4.1 General provisions

(a) [All] **Except as otherwise provided by law, all** Authority records [which are] required by law [or regulation] to be made, maintained, or kept on file shall be available to any individual [during regular business hours] for the purpose of inspection or hand copying **during regular business hours at the Authority's main offices at the Administration Building, Turnpike Interchange 9 at Route 18 North, East Brunswick, New Jersey. Other records within the possession of the Authority may be made available for inspection or hand copying subject to N.J.A.C. 19:9-4.2.**

(b) Except as otherwise specified herein, copies of [such] records may be obtained by written request [accompained by a check or money order made payable to the New Jersey Turnpike Authority in accordance with the following fee schedule] to:

New Jersey Turnpike Authority
Law Department
Records Request
P.O. Box 1121
New Brunswick, New Jersey 08903

[1. Documents up to 8½ by 13 inches, per page $.50;
2. Documents larger than 8½ by 13 inches, per page $1.00;
3. Drawings, maps and plan sheets, per page $1.00;
4. Microfilm, per page or sheet $1.00.

(c) No payment may be required when the request is made by the United States, the State of New Jersey or any agency or political subdivision thereof; individuals or firms doing work or performing services for the authority; organizations or associations of which the New Jersey Turnpike Authority is a member; and organizations exchanging information with the authority on a reciprocal basis.]

(c) Copies of New Jersey State Police Troop D accident reports concerning accident on the Turnpike may be obtained upon payment of a $10.00 report charge payable to the New Jersey Turnpike Authority, accompanied by a written request to:

New Jersey Turnpike Authority
Operations Department
Accident Report Request
P.O. Box 1121
New Brunswick, New Jersey 08903

[(d) Records in connection with a claim against the Authority, its agents, servants or employees, will be furnished only in accordance with the New Jersey court rules.]

(d) Criminal reports statements, photographs and other evidential reports, if any, attached to accident reports will be furnished only in accordance with applicable laws and the New Jersey court rules.

(e) Photographs of the Turnpike roadway, structures and/or appurtenances will be taken by the Authority upon written request to the Director of Public Affairs at the address set forth in (b) above. Requests must specify the exact location of the site, accompanied by a brief description of the item to be photographed. Such photographs shall not be taken by persons other than those employed or contracted by the Authority without first making written or verbal request to the Director of Public Affairs, whose approval shall be subject to the terms of N.J.A.C. 19:9-1.6(j).

(f) Records sought in connection with a claim or suit against the Authority, its agents, servants or employees, will be furnished only in accordance with applicable laws and the New Jersey court rules.

(g) Copies of bid documents for contractors and vendors bidding on work, services or materials shall be obtained at fees established by the Turnpike Authority to cover printing and distribution costs and published in the advertisement for the receipt of bids.

(h) The fees for obtaining Authority records, which are set forth in N.J.A.C. 19:9-4.4 shall be collectable at or before delivery of the documents copied. Payment shall be made by check or money order payable to the New Jersey Turnpike Authority.

[19:9-4.2 Photographs, slides

(a) Any individual requesting photographs or slides of the New Jersey Turnpike or any facility located thereon shall make written request to the Director of Public Information of the Turnpike Authority in accordance with the following fee schedule:

1. Photographs up to 8 by 10 inches, black and white glossy, per picture $10.00;
2. Photographs 8 by 10 inches, color glossy, per picture $15.00;
3. Slides, 35 millimeter, per slide $10.00.

(b) Photographs of the New Jersey Turnpike roadway, structures and/or appurtenances will be taken upon written request, addressed to the Director of Public Information. Requests must specify the exact location of the site, accompanied by a brief description of the item to be photographed. All requests shall be accompanied by a check or money order made payable to the New Jersey Turnpike Authority in accordance with the following fee schedule:

1. One 8 inches × 10 inches black and white single weight glossy: $30.00 for the first photo; all additional photos, $15.00 each. These prices include travel time, materials and film processing.

(c) If the New Jersey Turnpike Authority, in its judgment, determines that the interests of law enforcement, public safety and welfare so require, no copy of the requested photograph will be made or furnished to the applicant. In such event, the applicant will be so informed and such fee accompanying the request for such copy shall be returned.]

19:9-4.2 Nonpublic information

(a) The following records, if not required by law to be made, maintained, or kept on file, may be deemed by the Director of Law not to constitute public records subject to the inspection, examination and copying provisions of this subchapter:

1. All evaluative reports or memoranda submitted to, or prepared by, the Authority, its consultants, agents, or employees;

2. All records that are interagency or intraagency communications other than statistical or factual tabulations of data or final Authority policy or determinations;

3. All records concerning applications for employment with the Authority;

4. All records containing personal, financial or proprietary information submitted by individuals, corporations, partnerships and other entities doing business or seeking to do business with the Authority;

5. All records which, if disclosed, would impair present or imminent contract awards or collective bargaining negotiations;

6. All records which, if disclosed, would constitute an invasion of personal privacy;

7. All records compiled for law enforcement or official investigatory purposes if their disclosure would interfere with law enforcement investigations or legislative, judicial, administrative, or disciplinary proceedings or hearings, or deprive a person of a right to a fair trial or hearing or impartial adjudication, or identify a confidential source or disclose confidential information relating to a criminal, administrative or disciplinary investigation, or reveal

criminal investigative techniques or procedures, except routine techniques or procedures, or where disclosure would endanger the life or safety of any person or prejudice the Authority's ability to seek judicial or administrative relief;

8. All records otherwise exempted from disclosure by State or Federal law; and

9. Any other documents protected by a privilege.

[19:9-4.3 Bid documents

Copies of bid documents for contractors and vendors bidding on work, services or materials shall be obtained at fees established by the Turnpike Authority and published in the advertisement for the receipt of bids.]

19:9-4.3 Procedures for obtaining Authority records

(a) Requests for inspection or copying of records shall be made in person or in writing to the Authority at the address set forth in N.J.A.C. 19:9-4.1. Each request must set forth the name and address of the party requesting the document, the reason for the request, and the intended use of the document. The Director of Law shall review all requests and shall notify the person making a request of the time and date, or alternative times and dates, that the records will be made available for inspection and copying. If the request is denied, the person will be notified of the denial and the reasons for such denial.

(b) Records shall be inspected only under the supervision of the Director of Law or such other officer or employee as may be designated by the Director of Law. Such inspections shall be made at the Administration Building during regular business hours or at such other times and/or locations as the Director of Law deems convenient.

(c) All duplication shall be done by, or at the request of, the Authority, and the charges shall be in accordance with those set forth in N.J.A.C. 19:9-4.4. If the Director of Law finds that there is no risk of damage, mutilation or loss of such records and that it would not be incompatible with the economic and efficient operation of the Authority, the Director of Law may permit an individual or entity seeking to copy more than 100 pages to use his or her own photographic process, approved by the Director of Law upon the payment of a reasonable fee, considering the equipment and the time involved, to be fixed by the Director of Law at not less than $10.00 nor more than $50.00 per day. If it is not practicable for the Authority to copy any document, that document will be copied commercially, and the person requesting the copy shall be charged a fee equal to the Authority's cost for such commercial reproduction.

[19:9-4.4 New Jersey State Police Reports

(a) Copies of New Jersey State Police accident reports of Troop D on the New Jersey Turnpike may be obtained by written request addressed to the following:

Commanding Officer, Troop D
New Jersey State Police
P.O. Box 1121
New Brunswick, New Jersey 08903.

1. Requests can be made by mail or by anyone applying in person.

(b) All requests must be accompanied by a check or money order made payable to the New Jersey Turnpike Authority in accordance with the following schedule:

1. All accident reports obtained in person $1.00;
2. All mailed accident reports $6.00.

(c) No payment is required when the request is made by a law enforcement agency of the United States, the State of New Jersey or any political subdivison thereof.

(d) Criminal reports, statements, photographs, and other evidential reports, if any, attached to accident reports will be furnished only in accordance with New Jersey court rules.

(e) In the event that the Commanding Officer, Troop D, in his discretion, determines that the interests of law enforcement and public safety require that the requested report not be furnished, the applicant will be so informed and the fee accompanying the request will be returned and the report will be furnished only in accordance with New Jersey court rules.]

19:9-4.4 Fees

(a) Copies of Authority records by the Authority shall be made available to the requesting individual or entity upon full payment of copying costs. Copying costs shall be determined in accordance with the following fee schedule:

1. Documents up to 8½ by 13 inches: $.50 per page;
2. Documents over 8½ by 13 inches: $1.00 per page;
3. Drawings, maps, and plan sheets: $1.00 per page;
4. Microfilm copies, any size: $1.00 per page;
5. Existing Photographs:
i. Photographs up to 8 by 10 inches, black and white glossy: $10.00 per picture;
ii. Photographs 8 by 10 inches, color glossy: $15.00 per picture;
6. Photographs taken upon request (prices include travel time, materials and film processing) up to 8 by 10 inches, black and white glossy:
i. First photograph: $30.00;
ii. Each additional photograph: $15.00;
7. Slides, 35 millimeter: $10.00 per slide;
8. State Police Accident reports, all pages $10.00;
9. State Police Photographs up to 8 by 10 inches, color glossy:
i. First photograph: $5.00;
ii. Each additional photograph: $3.00.

(b) Payment may be waived when the request is made by the United States, the State of New Jersey, or any agency or political subdivision thereof, individuals or firms doing work or performing services for the Authority, organizations or associations of which the Authority is a member, credentialed media organizations, and organizations exchanging information with the Authority on a reciprocal basis.

(c) A fee of $5.00 per document or photograph will be charged for certification by the Secretary of the Authority that an Authority document is authentic or that a record of which the Authority is legal custodian cannot be found.

SUBCHAPTER 5. ADMINISTRATIVE PRACTICES

19:9-5.1 Pre-employment screening

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

(c) A medical examination, including drug screening, may be performed on any applicant for employment by the Authority's designated medical representative. Annual medical evaluations may subsequently be performed on all employees, and for appropriate personnel, may include drug screening.

19:9-5.2 Waivers generally

Nothing in these rules shall be construed to prohibit the Authority from granting waivers from any provisions hereof, the New Jersey Turnpike Authority Standard Specifications.

19:9-5.3 Procedure for waiver

Any party desiring a waiver or release from the express provisions of any of these rules, the New Jersey Turnpike Authority's Standard Specifications shall submit a written request to the Executive Director. Any waiver so requested may be granted only upon a finding that such waiver would not jeopardize the health, safety or welfare of the Turnpike, its patrons or the general public, would not contravene the provisions of N.J.S.A. 27:23-1 et seq., and that granting the waiver would be consistent with the Authority's statutory purposes.

SUBCHAPTER 7. ORGANIZATION OF THE NEW JERSEY TURNPIKE AUTHORITY

19:9-7.1 Authority responsibilities

The [New Jersey Turnpike] Authority is responsible for the design, construction, maintenance and operation of a limited access, high-speed roadway [and], for related projects **designed at N.J.S.A. 27:23-1 et seq. and for such other activities as may be authorized by law.**

19:9-7.2 Table of organization

A table of organization showing the general course and method of operation within the Authority is appended to this chapter as Appendix [A] **B**, incorporated herein by referenece.

19:9-7.3 Functions of departmental units

(a) Functions of the various departments within the [New Jersey Turnpike] Authority are as follows:

1. (No change.)

2. Maintenance: This department is responsible for the care and maintenance of **the Authority's** existing [Turnpike] facilities**, real property, equipment and communications system.**

3. (No change.)

4. Operations: This department manages all activities related to day-to-day operation of the Turnpike. Its responsibilities include traffic engineering, traffic regulations, emergency services, coordination of construction and maintenance activities, hazardous materials [training] **response**, employee safety, communications, **towing and hazardous materials concessionaires,** and liaison with the New Jersey State Police assigned to the Turnpike.

5. Finance and Budgets: This department is responsible for all fiscal matters for the Authority, including financing and investment issues, annual capital and operating budgets, asset management, payroll, [and] other disbursements**, and toll collection audits.**

6. Law: This department provides legal service to all [Turnpike] Authority departments, including the review of contracts, acquisition of property, management of all legal and quasi-legal hearings, the handling of matters associated with labor relations, and the performance of contract administration duties. In addition, this department has all responsibility for [Risk Management] **risk management and insurance** functions and operations.

7. Human Resources: This department is responsible for all employment activities (recruiting, promotions, etc.), labor relations management, training of Authority employees, and administration of [the] employee benefits [program] **programs**.

8. Administrative Services **and Technology**: This [Department] **department** is responsible for **concessionaire services (including road service) and for** providing [necessary] support services to the Authority departments and [all] its employees[. Management Information Systems provides design, development and installation of all real-time, on-line office]**, including** management [and batch] information systems[. Office Services provides centralization of supplies necessary to conduct business for all Authority departments. In addition, this section is responsible for all]**, office services,** mail activities [and]**,** duplication [requests. Purchasing is responsible for the procurement]**, purchasing** of all materials, supplies, and services for the maintenance, repair and operation of all [Authority Departments. This section also maintains responsibility for the] **departments, and** management of the disposal of surplus property.

9. Public Affairs: This [Department] **department** coordinates Authority interaction with the media, provides information to the press[,] **and public and** manages all community relations[, all patron services activities including complaints, requests for information, and the like].

10. Secretary to the Authority: This [position] **office** manages all activities of the Authority's [Commission] **Commissioners**, and manages the official records **of the** Authority and their disposition [for the Authority].

19:9-7.4 Information

Interested persons can obtain information from the Authority by addressing inquiries to:

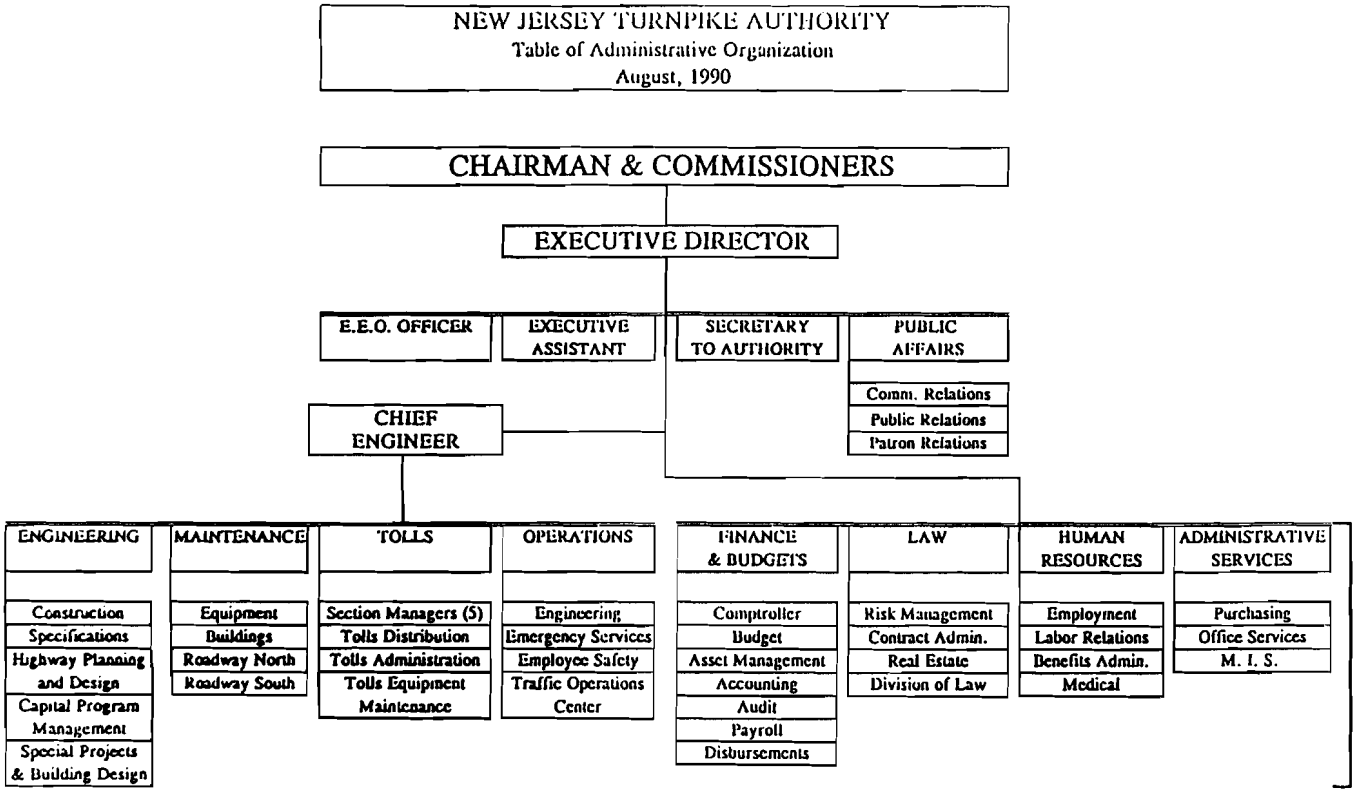
[Donald L. Watson,] Executive Director
New Jersey Turnpike Authority
P.O. Box 1121
New Brunswick, NJ 08903

[EXHIBIT A
CONTRACTOR'S CLASSIFICATION

Classification	Brief Description
1. Bridge Structures	Bridge, viaducts, retaining walls, foundations, fabrication and erection of structural steel, intermediate members, deck repair and/or replacement.
2. Communications	Installation and testing of switching equipment, telecommunications and all other communication systems.
3. Computer Systems	Fabrication of computer system, installation, electrical and other work incidental thereto, including associated software.
4. Concrete Maintenance	Concrete repairs, concrete sawing, sealing, curing.
5. Demolition	Demolition and/or removal of buildings, structures.
6. Dredging	Grading and drainage, excavation, embankment, fill, subgrade material, muck removal—primarily by dredging methods.
7. Electrical Work, Buildings	All electrical work for buildings.
8. General Construction, Buildings	General construction of buildings, including all incidental work.
9. General Construction, Highway	Work involving grading, drainage, paving (no bridges).
10. Grading and Drainage	All grading and drainage, clearing, including drainage structures.
11. Guard Rail and Fencing	All types of guard rail, all types of fencing.
12. Heating, Ventilating and Air Conditioning	All heating, ventilating, air conditioning work involved for building construction.
13. Heavy Highway	Work involving any combination of excavation, grading, drainage, paving, bridges.
14. Kitchen Equipment	Fabrication, installation of kitchen and restaurant equipment for buildings.
15. Landscaping	Planting, seeding, topsoiling, grading, jute mesh, erosion control and all other landscaping procedures.
16. Electrical Work, Highway	Roadway, area, parking and ramp lighting, lighting standards, electrical distribution panels and other underground and overhead electrical work.
17. Painting	Cleaning, priming, painting of structural steel and members (bridges, towers, tanks).
18. Paving	Work involving all types of paving, new and resurfacing.
19. Plumbing	All plumbing work for building construction including sanitary facilities.
20. Sewerage and Water Supply	Construction of sewerage and water treatment plants, including structures and equipment, installation and repair; erection, repair and/or replacement of water towers.
21. Signing	All types of signing, delineation, overhead sign structures.
22. Structural Steel & Iron Buildings	Fabrication and erection of structural steel for buildings, including reinforcing, and ornamental iron work.

23. Toll booths and Equipment	Toll booth fabrication and installation, toll collection equipment, canopies, roofing, soffit lane lights, luminous signing.
24. Special Classifications	Specialized work not sufficiently included in other defined classifications; such as, but not limited to the following:
Toll Revenue and Computer Systems	Toll revenue system design fabrication, testing, installation, including associated computer and communication subsystems with software development.
Timber Construction	Bridge fender systems and all types of timber construction.
Architectural Metal Panel Construction	All types of architectural metal panel construction.
Fencing	All types of fencing.
Fuel Distribution Systems	Construction of fuel distribution systems including installation of dispensers, storage tanks, and all associated electrical work and piping.
Interior Furnishings	Carpeting and other interior furnishings.
Water Supply Well Construction and Rehabilitation	Construction, rehabilitation and testing of water supply wells.
Lining Fuel Storage Tanks	Epoxy resin lining of fuel storage tanks.
Automotive Service Equipment	Vehicle lifts and all types of automotive service equipment.
Concrete Median Barrier	Construction and installation of precast or cast-in-place concrete median barrier, sidewalks, curbs and other similar concrete components.
Bridge Drainage Systems	Construction and modification of bridge supported and in-ground bridge drainage systems.
Prefabricated Buildings	Installation of all types of prefabricated buildings.
Roofing	Construction and rehabilitation of all types of roofing systems.
Fire Protection Systems	Construction of dry chemical, pre-engineered and CO_2 type fire protection systems.
CLASSIFICATION RATING:	A. Up to $150,000 maximum B. Up to $500,000 maximum C. Up to $1,000,000 maximum D. Up to $2,000,000 maximum E. Up to $5,000,000 maximum F. Unlimited Special Rating—(limits to be established in specific situations where other Classification Rating is not adequate)]

[APPENDIX A



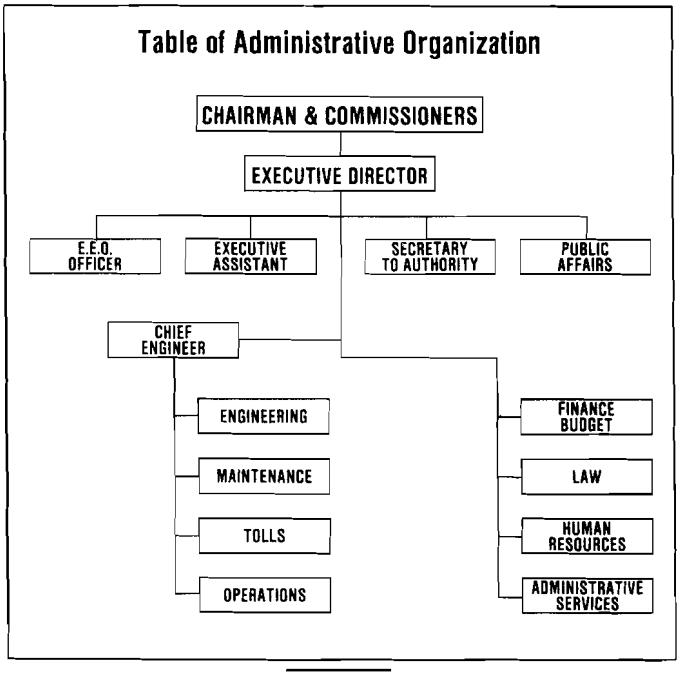
APPENDIX A
SCHEDULE OF CLASSIFICATIONS

Classification	Brief Description
1. Bridge Structures	Bridge, viaducts, retaining walls, foundations, fabrication and erection of structural steel, intermediate members, deck repair and/or replacement.
2. Communications	Installation and testing of switching equipment, telecommunications and all other communication systems.
3. Computer Systems	Fabrication of computer system, installation, electrical and other work incidental thereto, including associated software.
4. Concrete Maintenance	Concrete repairs, concrete sawing, sealing, curing.
5. Demolition	Demolition and/or removal of buildings, structures.
6. Dredging	Grading and drainage, excavation, embankment, fill, subgrade material, muck removal—primarily by dredging methods.
7. Electrical Work, Buildings	All electrical work for buildings.
8. General Construction, Buildings	General construction of buildings, including all incidental work.
9. General Construction, Highway	Work involving grading, drainage, paving (no bridges).
10. Grading and Drainage	All grading and drainage, clearing, including drainage structures.
11. Guard Rail and Fencing	All types of guardrail, all types of fencing.
12. Heating, Ventilating and Air Conditioning	All heating, ventilating, air conditioning work involved for building construction.
13. Heavy Highway	Work involving any combination of excavation, grading, drainage, paving, bridges.
14. Kitchen Equipment	Fabrication, installation of kitchen and restaurant equipment for buildings.
15. Landscaping	Planting, seeding, topsoiling, grading, jute mesh, erosion control and all other landscaping procedures.
16. Electrical Work, Highway	Roadway, area, parking and ramp lighting, lighting standards, electrical distribution panels and other underground and overhead electrical work.
17. Painting	Cleaning, priming, painting of structural steel and members (bridges, towers, tanks).
18. Paving	Work involving all types of paving, new and resurfacing.
19. Plumbing	All plumbing work for building construction including sanitary facilities.
20. Sewerage and Water Supply	Construction of sewerage and water treatment plants, including structures and equipment, installation and repair; erection, repair and/or replacement of water towers.
21. Signing	All types of signing, delineation, overhead sign structures.
22. Structural Steel and Iron Buildings	Fabrication and erection of structural steel for buildings, including reinforcing, and ornamental iron work.
23. Toll booths and Equipment	Toll booth fabrication and installation, toll collection equipment, canopies, roofing, soffit lane lights, luminous signing.
24. Special Classifications	Specialized work not sufficiently included in other defined classifications; such as, but not limited to the following:
Toll Revenue and Computer Systems	Toll revenue system design fabrication, testing, installation, including associated computer and communication subsystems with software development.
Timber Construction	Bridge fender systems and all types of timber construction.
Architectural Metal Panel Construction	All types of architectural metal panel construction.
Fencing	All types of fencing.
Fuel Distribution Systems	Construction of fuel distribution systems including installation of dispensers, storage tanks, and all associated electrical work and piping.
Interior Furnishings	Carpeting and other interior furnishings.
Water Supply Well Construction and Rehabilitation	Construction, rehabilitation and testing of water supply wells.
Lining Fuel Storage Tanks	Epoxy resin lining of fuel storage tanks.
Automotive Service Equipment	Vehicle lifts and all types of automotive service equipment.
Concrete Median Barrier	Construction and installation of precast or cast-in-place concrete median barrier, sidewalks, curbs and other similar concrete components.
Bridge Drainage Systems	Construction and modification of bridge supported and in-ground bridge drainage systems.
Prefabricated Buildings	Installation of all types of prefabricated buildings.
Roofing	Construction and rehabilitation of all types of roofing systems.
Fire Protection Systems	Construction of dry chemical, pre-engineered and CO_2 type fire protection systems.
Telephone Systems	Design, fabrication and installation of computer controlled telephone systems with special interfaces including testing, equipment maintenance, software development and owner training.
Asbestos Removal/ Treatment	Work involving removal, replacement, repair, enclosure, encapsulation, and/or legal disposal of asbestos and asbestos containing materials.
Local Area Network	Contractor has provided a complete baseband or broadband local area network, such as "Ehernet", Manufacturing Automation Protocol (MAP) or "Token Ring." These installations shall also include related electrical work.

	Basic materials involved consist of coaxial cable, communications cable, radio cable, connectors, terminal blocks, equipment jacks, modems, terminal servers, routers, transceivers, electronic enclosures, and other miscellaneous components. This type of work shall be demonstrated to have been completed by the Contractor and not subcontracted to others.
Pre-cast-Concrete Noise Barriers	**Fabricating and furnishing reinforced precast concrete noise barriers consisting of sound absorbing materials of lightweight concrete or mineralized wood chips and portland cement such as "Sound-Lok" as manufactured by Easi-Set Industries, Midland, VA or "Durisol" as manufactured by Fanwell Corp., Arlington, VA.**
	Fabricating plant must be capable of fabricating 5,000 square feet per day of precast concrete noise barrier panels and storing 200,000 square feet of such panels.
Signing—Fabrication only	**Fabricating and furnishing all types of signing, delineation and overhead sign structures.**
Traffic Control Electronics and Association Equipment	**Fabrication, testing and installation of traffic control unit enclosures complete with electronics and associated computer subsystems.**
Precast-Concrete Noise Barriers—Non-Absorptive Materials	**Fabrication and furnishing reinforced precast concrete noise barrier system components consisting of posts and modular panels. Fabrication methods shall employ form liners for precasting standard materials consisting of concrete, reinforced with epoxy coated deformed bars. No sound absorptive materials should be integratged within these barrier components.**
	Fabricating plant must be capable of fabricating 5,000 square feet per day of precast concrete noise barrier panels and storing 200,000 square feet of such panels.
CLASSIFICATION RATINGS:	**A. up to $150,000 maximum**
	B. up to $500,000 maximum
	C. up to $1,000,000 maximum
	D. up to $2,000,000 maximum
	E. up to $5,000,000 maximum
	F. up to $10,000,000 maximum
	G. Unlimited

Special Rating—(Limits to be established in specific situations where other Classification Rating is not adequate)

APPENDIX B
TABLE OF ORGANIZATION



(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Count Rooms; Characteristics
Slot Count; Procedure for Counting and Recording Contents of Slot Drop Buckets; Presence of Commission Inspectors

Proposed Amendments: N.J.A.C. 19:45-1.32 and 1.43

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.
Authority: N.J.S.A. 5:12-63(f), 69(a), 70(l), 99(a)8 and 100(c).
Proposal Number: PRN 1993-371.

Submit written comments by August 4, 1993 to:
Seth H. Briliant, Assistant Counsel
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, NJ 08401

The agency proposal follows:

Summary

Section 63(f) of the Casino Control Act, N.J.S.A. 5:12-63(f), requires the Commission to "be present through its inspectors and agents at all times during the operation of a casino for the purpose of certifying the revenue thereof." Current Commission regulations require a Commission inspector to be present in the "count room" at all times when monies collected from the casino floor are counted. N.J.A.C. 19:45-1.43(c). Depending upon the size of the casino and the time of year, the time that an inspector's presence is required in the count room could exceed eight hours. If the inspector must leave the count room, all monies in the room must be secured and the count suspended until the inspector returns.

These proposed amendments would revise certain count room procedures and permit the counting of certain denominations of slot tokens and coin in the "hard count" room without a Commission inspector being present. This arrangement would free the inspector to perform other priority tasks outside the count room, yet permit the count to continue uninterrupted, while not impairing the integrity or security of the count process.

Under the proposed procedure, the names and employee license numbers of the count room personnel present at the inception of the count would be documented for later comparison with the personnel present at the conclusion of the count. The accuracy of the scales, wrapping machines, and all other counting equipment would also be tested in the presence of the inspector, who would retain a calibration report for future use. N.J.A.C. 19:45-1.43(i)(1)i and ii.

All tokens in denominations of $25.00 or more would then be weighed, counted and secured first, in the presence of the inspector, who would obtain and retain a "countdown sheet," to be used later for comparison with and verification of the final count, as shown on the Slot Win Sheet. Once the foregoing tasks and the count of the higher denomination tokens has been completed, the Commission inspector could leave the count room while the rest of the count is being conducted, and then return prior to the final countdown. N.J.A.C. 19:45-1.43(i)8.

If the inspector does leave during the count, the casino surveillance department would have to be notified beforehand of the inspector's departure. Upon his or her departure, the inspector would activate a light system or other device approved by the Commission. N.J.A.C. 19:45-1.43(i)8i and ii. This device would be at the count room door, and would also be connected to the Commission booth. When activated, the device would light or otherwise visually indicate whenever the door to the count room is opened, and could be deactivated and reset only by a Commission inspector. N.J.A.C. 19:45-1.32(d)2. Thus, it will be readily apparent if anyone enters or exits the count room without Commission authorization while an inspector is not there.

While no inspector is present, there should be no movement in or out of the count room except in a emergency. If, for example, a mechanic is needed to service the counting equipment, the control box would have to be deactivated by the inspector to permit entry; if the mechanic later needed to leave the room, the same procedure would need to be repeated, and he or she would also have to be "wanded" with metal detection equipment by casino security department personnel, in the presence of the inspector. N.J.A.C. 19:45-1.43(i)8.

At least 15 minutes prior to completing the count, the count team would notify the Commission booth. An inspector would then re-enter the room, review the personnel list and examine the control box to verify that the persons in the count room remained unchanged in his or her absence. N.J.A.C. 19:45-1.43(j). The inspector would also verify the amount of the high denomination slot tokens counted at the inception of the count, by comparing the original countdown sheet with the Slot Win Sheet.

Once the high denomination token count and any personnel changes have been verified to the inspector's satisfaction, as well as the amount of all other tokens and coin counted, the cage cashier would be permitted to purchase the coin and tokens counted, and the count would conclude. All count room employees would be wanded with metal detection equipment prior to leaving the count room, and the room would be inspected by casino security personnel for any unsecured coin or tokens. The inspector must be present at the conclusion of the count, through the buying of the count, the wanding process, and the inspection of the room. If there are any changes in personnel or any variations in the amounts of the high denomination tokens between the beginning and the end of the count, and such personnel changes or token variations cannot be accounted for, the inspector would document the incident and notify the Division. N.J.A.C. 19:45-1.43(j)2ii and (j)5.

The amendments also clarify, streamline, and recodify related subsections of the regulations dealing with the hard count procedure, such as N.J.A.C. 19:45-1.43(a), (b), and (e), and (g), but make no substantive changes in those procedures.

Social Impact

No significant social impact is anticipated, since these amendments only address the physical requirements of count rooms and the procedures that must be used if a Commission inspector is not present during portions of the hard count.

However, to the extent this procedure gives the Commission inspection staff some flexibility in supervising count rooms, it should also permit them to attend to other priority matters. This should enable the inspectors to make even more efficient and productive use of their time without impairing or jeopardizing the security and integrity of the count process.

Economic Impact

These amendments will require that casino licensees incur some expenses to install the required light system or other device at the hard count room door which must be connected to the Commission booth. But it is hoped that this amendment will have a positive economic impact upon casino licensees, by permitting the count process to proceed uninterrupted, even if a Commission inspector leaves after the higher denomination tokens have been counted and secured. Because these amendments will also permit Commission inspectors to perform other important functions during portions of the hard count process, both the Commission and casino licensees should realize positive economic benefits from the amendments.

Regulatory Flexibility Statement

The proposed amendments will affect only New Jersey casino licensees, none of which is a "small business" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16, et seq. Accordingly, a regulatory flexibility analysis is not required.

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

19:45-1.32 Count rooms; characteristics

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

(d) The count room designated for counting **the** contents of slot drop buckets and slot drop boxes, if a different room [than] **from** that used for counting **the** contents of drop boxes and slot cash storage boxes, shall meet all requirements [herein] **contained in (a) through (c) above** except for the **requirements concerning** audio capabilities. In addition, the room shall contain [either a]:

1. A fixed-door type or hand-held metal detector to inspect all persons exiting the count room; **and**

2. A light system or other device approved by the Commission which shall provide a continuous visual signal at the count room door, the Commission booth and such other locations as the Commission may require whenever the count room door is opened while the system is activated. The light system or device shall:

i. Maintain the visual signal until the system is reset or deactivated; and

ii. Be designed so as to permit its activation, deactivation or resetting only by a Commission inspector.

19:45-1.43 Slot count; procedure for counting and recording contents of slot drop buckets

(a) The **counting and recording of the** contents of slot drop buckets **(the "hard count")** shall be [counted and recorded in conformity with this section] **performed in the count room required pursuant to N.J.A.C. 19:45-1.32 by at least three employees of the casino licensee (the "count team"). Except as otherwise provided in (i) below, the hard count shall be performed in the presence of a Commission inspector. To gain entrance to the count room, a Commission inspector shall present an official identification card issued by the Commission which contains his or her photograph.**

(b) The contents of slot drop buckets shall be counted and recorded immediately after the buckets and boxes are removed from their slot machine compartments. Each casino licensee shall file with the Commission and the Division the specific times during which the contents of slot drop buckets [removed from compartments are to] **shall** be counted and recorded[, which shall be immediately after removal of the drop buckets from their compartments].

[(c) The opening, counting and recording of the contents of slot drop buckets shall be performed in the presence of a Commission inspector by at least three employees ("Count Team") with no incompatible functions. To gain entrance to the count room, the Commission inspector shall present an official identification card containing his photograph issued by the Commission.]

[(d)](c) All [persons] **members of the count team** present[, except representatives of the Commission and Division,] in the count room during the counting process shall **be required to** wear [as outer garments, only] a full-length, one-piece, pocketless **outer** garment with **no** openings [only] **other than** for the arms, **legs,** feet, and neck.

[(e)](d) No person [present] shall carry a pocketbook or other container into the count room **at any time** unless it is transparent.

(e) No person other than a Commission inspector or Division representative shall be permitted to enter or leave the count room during the hard count, except in an emergency or for a normal work break, until the hard count is completed. All persons exiting the count room shall be inspected with a metal detector by a casino

security department employee in the presence of a Commission inspector. The counting and recording process shall be discontinued and all coin and slot tokens shall be secured during any work break or emergency where the minimum number of count room personnel required by (a) above are not present or are not capable of performing their responsibilities.

(f) Immediately prior to counting the contents of the slot drop buckets, the doors to the count room shall be securely locked[, the counting devices to be used shall be checked for accuracy by employees with no incompatible functions, and, except as required by (j)2 below, no person shall be permitted to enter or leave the count room, except during a normal work break or in an emergency, until the entire counting and recording process is completed. During a work break or in the event of an emergency, the counting and recording process shall be discontinued unless the appropriate number of personnel as described in (c) above are present.

(g) Immediately prior to the commencement of the count, one] **and a** count team member shall notify the [person] **the surveillance department employee** assigned to the closed circuit television monitoring [station in the establishment] **room required by N.J.A.C. 19:45-1.10** that the count is about to begin[, after which such person shall]. **The surveillance department shall also be notified prior to any person entering or exiting the count room after the hard count has begun.**

(g) The surveillance department shall monitor and make a video recording, with the time and date inserted thereon, of the entire [counting process] **hard count**, including [the] **any entrance to or exit from the count room by any person during the hard count and all** metal detector [check] **inspections performed** by **casino** security[, which]. **The video recording** shall be retained by the surveillance department for at least five days from the date of recordation unless otherwise directed by the [commission] **Commission** or the [division] **Division.**

(h) [Coin] **No coins or slot tokens** shall [not] be removed from the slot count room after commencement of the **hard** count until the [coin has] **coins or slot tokens have** been recounted and accepted by a cage cashier. The recount procedures shall include the recounting of any bagged coins **or slot tokens** on a random sample basis.

(i) Procedures and requirements for conducting the **hard** count shall be [the following] **as follows:**

1. Prior to the first slot drop bucket being emptied and counted, employees of the casino licensee shall:

i. Provide the name and the employee license number of each person present in the count room at the inception of the hard count to the Commission inspector observing the hard count;

ii. Check, in the presence of the Commission inspector, the accuracy of all weighing, wrapping, and other counting equipment to insure proper calibration for each denomination of coin and slot token; and

iii. Complete and sign a calibration report.

2. All slot tokens in denominations of $25.00 or more shall be counted or weighed in the presence of the Commission inspector prior to any other slot tokens or coins being counted or weighed. The Commission inspector shall, independently of the casino licensee, record on a countdown sheet the total amount of each slot token in a denomination of $25.00 or more which is counted or weighed. The inspector shall compare the totals on his or her countdown sheet to the final totals determined by the casino licensee at the conclusion of the hard count.

[1.]**3.** Before each slot drop bucket is emptied, one count team member shall hold **it** up [the slot drop bucket,] in full view of the closed circuit television camera and the [person] **count team member** recording the count[,] **so as** to [properly record] **permit proper recording of** the number **contained** thereon[;].

[2.]**4.** The contents of each slot drop bucket shall be emptied, counted and recorded separately and such procedures shall at all times be conducted in full view of the closed circuit television cameras located in the count room[;].

[3.]**5.** The [coin] contents of each slot drop bucket shall be emptied separately into either a machine that automatically counts the coins [placed therein] or a scale that automatically weighs the coins [placed therein;].

[4.]**6.** Immediately after the [coin] contents of each slot drop bucket are emptied into either the [count] **counting** machine or scale, [or if currency, on a table in the count room,] the inside of the slot drop bucket shall be held up to the full view of the closed circuit television camera and shall be shown to at least one other [slot] count team member and the Commission inspector**, if present,** to assure **that** all contents of the slot drop bucket or slot drop box have been removed[;].

[5.]**7.** As the contents of each slot drop bucket are counted by the [count] **counting** machine or weighed by the scale, [or, if currency, by two count team members,] one member **of the count team** shall record on the Slot Win Sheet[,] or **a** supporting document, the asset number of the slot machine to which the slot drop bucket contents corresponds, if not preprinted thereon, and the number of coins **or slot tokens**, or the weight of the [coin and/or currency counted] **coins or slot tokens contained in the slot drop bucket.** If the [coin] value **of the coins or slot tokens** is not converted **into dollars and cents** until after the [count] **counting process** is completed, the conversion shall be [prepared] **calculated** and the dollar value of the drop shall be entered by denomination on the Slot Win [Report;] **Sheet.**

8. After all slot tokens in denominations of $25.00 or more have been counted, wrapped and then secured in a manner approved by the Commission, the Commission inspector may leave the count room to perform other functions as required by the Commission. Upon leaving the count room, the inspector shall:

i. Notify the surveillance department of his or her departure; and

ii. Activate the light system or other approved device at the count room door required by N.J.A.C. 19:45-1.32(d).

9. No person shall enter or leave the count room during the hard count when a Commission inspector is not present except in an emergency.

[6.]**10.** After the contents of all the slot drop buckets are counted or weighed and recorded, each count team member shall sign the Slot Win Sheet or other document as approved by the Commission attesting to their involvement in the **hard** count[;].

[7.]**11.** After the contents of all the slot drop buckets are counted or weighed and recorded, any count team [employees] **member** not required **to remain** pursuant to [(i)7ii] **(i)11ii** below may be permitted to exit the count room [provided that] **if** the following requirements are satisfied:

i. The Slot Win Sheet or other approved document must be signed by each [employee] **count team member** exiting the count room, in accordance with [(i)6] **(i)10** above;

ii. At least three count team [employees] **members** must remain in the count room until the verification process is completed;

iii. [Surveillance] **The surveillance department** must be notified prior to any [employees] **count team members** exiting the count room;

iv. All activity in the [hard] count room shall be discontinued during any period when [an employee] **a count team member** is exiting the count room; and

v. A **casino** security department employee shall check all [persons] **count team members** leaving the count room with a metal detector, in the presence of a Commission inspector, at a location approved by the Commission and Division [and;].

[8.]**12.** At the conclusion of the **hard** count [process], any slugs that have been found [during the slot drop bucket pick-up or count process will] **shall** be delivered to [an agent] **a representative** of the Division together with a copy of the Slug Report. The Slug Report shall be a three-part form, at a minimum, which shall include the date, the total number of slugs received and the signature of the preparer, and shall be distributed as follows:

i.-iii. (No change.)

(j) Procedures and requirements at the conclusion of the **hard** count shall be [the following] **as follows**:

1. Approximately 15 minutes prior to the end of the hard count, if a Commission inspector is not present, an inspector shall be notified that the hard count is about to be completed.

2. Upon reentering the count room, the Commission inspector shall:

i. Examine the light system or other approved device to ascertain whether any person has entered or exited the count room during the period of his or her absence, and if so, either satisfactorily account for those events, if possible, or document the incident and promptly report it to the Division; and

ii. Compare the original list of count team members with the persons present at the conclusion of the hard count, ascertain whether the identities of the persons in the count room remained unchanged during the hard count, and if not, either satisfactorily account for any changes in personnel, if possible, or document the incident and promptly report it to the Division.

[1.]**3.** (No change in text.)

[2.]**4.** The wrapped coin and [currency] **slot tokens** removed from the slot drop buckets shall be [counted] **recounted** in the count room **by a cage cashier or master coin bank cashier,** in the presence of a count team member and [a] **the** Commission inspector, [by a cage cashier or master coin bank cashier,] prior to the cashier having access to the information recorded on the Slot Win Sheet.

5. The inspector shall then compare the amounts of the slot tokens listed on his or her countdown sheet with the amounts of those tokens shown on the Slot Win Sheet, and verify that the amounts are in agreement and are correct, and if not, either satisfactorily account for any discrepancies, if possible, or document the incident and promptly report it to the Division.

6. The cage cashier or master coin bank cashier shall **then** attest by signature on the Slot Win Sheet to the accuracy of the amount of coin and [currency] **slot tokens** received from the slot machines[; after which the]. **The** [Commission] inspector shall **then** sign the Slot Win Sheet evidencing the inspector's presence [during the count] and the fact that [both] **the inspector,** the cashier and count team have agreed on the total amount of coin and [currency] **slot tokens** counted. The coin and [currency] **slot tokens** thereafter shall remain in the custody of cage cashiers or master coin bank cashiers.

[3.]**7.** A **casino** security department employee, **in the presence of the Commission inspector,** shall [check]:

i. Inspect all persons with a metal detector upon their exiting the count room[.]; **and**

ii. Conduct a thorough inspection of the entire count room and all equipment located therein, for unsecured coins and slot tokens.

[4.]**8.** (No change in text.)

[5.]**9.** The preparation of the Slot Win Sheet shall be completed by accounting department employees [with no incompatible functions as follows] **who shall:**

i. Compare for agreement, for each slot machine, the number of coins [and/or amount of currency] **or slot tokens** counted and recorded by the count team to the drop meter reading recorded on the Slot Meter Sheet;

ii.-vi. (No change.)

[6.]**10.** (No change in text.)

RULE ADOPTIONS

AGRICULTURE

(a)

DIVISION OF ADMINISTRATION

Notice of Administrative Correction
Disability Discrimination Grievance Procedure
N.J.A.C. 2:1-4

Take notice that the Office of Administrative Law has discovered an error in the publication of the adopted text of N.J.A.C. 2:1-4 published in the June 7, 1993 New Jersey Register at 25 N.J.R. 2247(b). The published notice of adoption inadvertently did not include the adopted text of N.J.A.C. 2:1-4.2 through 4.8 (see 25 N.J.R. 1314(a) and 1338(a)). This notice of administrative correction, which provides the missing text, is published pursuant to N.J.A.C. 1:30-2.7.

Full text of the corrected subchapter follows (additions indicated in boldface **thus**:

SUBCHAPTER 4. DISABILITY DISCRIMINATION GRIEVANCE PROCEDURE

2:1-4.1 Definitions

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

"ADA" means the Americans with Disabilities Act, 42 U.S.C.A. §12101 et seq.

"Agency" means the New Jersey Department of Agriculture.

"Designated decision maker" means the Secretary of Agriculture or his or her designee.

2:1-4.2 Purpose

(a) These rules are adopted by the agency in satisfaction of the requirements of the ADA and regulations promulgated pursuant thereto, 28 C.F.R. 35.107.

(b) The purpose of these rules is to establish a designated coordinator whose duties shall include assuring that the agency complies with and carries out its responsibilities under the ADA. Those duties shall also include the investigation of any complaint filed with the agency pursuant to N.J.A.C. 2:1-4.5 through 4.8.

2:1-4.3 Required ADA Notice

In addition to any other advice, assistance or accommodation provided, a copy of the following notice shall be given to anyone who inquires regarding the agency's compliance with the ADA or the availability of accommodation which would allow a qualified individual with a disability to receive services or participate in a program or activity provided by the agency.

AGENCY NOTICE OF ADA PROCEDURE

The agency has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by the U.S. Department of Justice regulations implementing Title II of the Americans with Disabilities Act. Title II states, in part, that "no otherwise qualified disabled individual shall, solely by reason of such disability, be excluded from participation in, be denied the benefits of or be subjected to discrimination" in programs or activities sponsored by a public entity.

Rules describing and governing the internal grievance procedure can be found in the New Jersey Administrative Code, N.J.A.C. 2:1-4. As those rules indicate, complaints should be addressed to the agency's designated ADA Coordinator, who has been designated to coordinate ADA compliance efforts, at the following address:

ADA Coordinator
New Jersey Department of Agriculture
CN 330
Trenton, New Jersey 08625

1. A complaint may be filed in writing or orally, but should contain the name and address of the person filing it, and briefly describe the alleged violation. A form for this purpose is available from the designated ADA coordinator. In cases of employment related complaints, the procedures established by the Department of Personnel, N.J.A.C. 4A:7-1.1 et seq. will be followed where applicable.

2. A complaint should be filed promptly within 20 days after the complainant becomes aware of the alleged violation. (Processing of allegations of discrimination which occurred before this grievance procedure was in place will be considered on a case-by-case basis).

3. An investigation, as may be appropriate, will follow the filing of a complaint. The investigation will be conducted by the agency's designated ADA Coordinator. The rules contemplate informal but thorough investigations, affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to a complaint.

4. In most cases a written determination as to the validity of the complaint and a description of the resolution, if any, will be issued by the designated decision maker and a copy forwarded to the complainant no later than 45 days after its filing.

5. The ADA coordinator will maintain the files and records of the agency relating to the complaints filed.

6. The right of a person to a prompt and equitable resolution of the complaint filed hereunder will not be impaired by the person's pursuit of other remedies such as the filing of an ADA complaint with the responsible Federal department or agency or the New Jersey Division on Civil Rights. Use of this grievance procedure is not a prerequisite to the pursuit of other remedies.

7. The rules will be construed to protect the substantive rights of interested persons, to meet appropriate due process standards and to assure that the agency complies with the ADA and implementing Federal rules.

2:1-4.4 Designated ADA coordinator

(a) The designated coordinator of ADA compliance and complaint investigation for the agency is:

ADA Coordinator
New Jersey Department of Agriculture
CN 330
Trenton, New Jersey 08625

(b) All inquiries regarding the agency's compliance with the ADA and the availability of accommodation which would allow a qualified individual with a disability to receive services or participate in a program or activity provided by the agency should be directed to the designated coordinator identified in (a) above.

(c) All complaints alleging that the agency has failed to comply with or has acted in a way that is prohibited by the ADA should be directed to the designated ADA coordinator identified in this section, in accordance with the procedures set forth in N.J.A.C. 2:1-4.5 through 4.8.

2:1-4.5 Complaint procedure

A complaint alleging that the agency has failed to comply with the ADA or has acted in a way that is prohibited by the ADA shall be submitted either in writing or orally to the designated ADA coordinator identified in N.J.A.C. 2:1-4.4. A complaint alleging employment discrimination will be processed pursuant to the rules of the Department of Personnel, N.J.A.C. 4A:7-1.1 through 3.4, if those rules are applicable.

2:1-4.6 Complaint contents

(a) A complaint submitted pursuant to this subchapter may be submitted in or on the form set forth at N.J.A.C. 2:1-4.7.

(b) A complaint submitted pursuant to this subchapter shall include the following information:

1. The name of the complainant, and/or any alternate contact person designated by the complainant to receive communication or provide information for the complainant;

2. The address and telephone number of the complainant or alternate contact person; and

3. A description of manner in which the ADA has not been complied with or has been violated, including times and locations of events and names of witnesses if appropriate.

2:1-4.7 Complaint form

The following form may be utilized for the submission of a complaint pursuant to this subchapter:

Americans with Disabilities Act Grievance Form

Date: _____

Name of grievant: _____

Address of grievant: _____

Telephone number of grievant: _____

Disability of grievant: _____

Name, address and telephone number of alternate contact person:

_____

_____

Agency alleged to have denied access:

Department: _____

Division: _____

Bureau or office: _____

Location: _____

Incident or barrier:

Please describe the particular way in which you believe you have been denied the benefits of any service, program or activity or have otherwise been subject to discrimination. Please specify dates, times and places of incidents, and names and/or positions of agency employees involved, if any, as well as names, addresses and telephone numbers of any witnesses to any such incident. Attach additional pages if necessary.

_____

_____

_____

_____

_____

_____

Proposed access or accommodation:

If you wish, describe the way in which you feel access may be had to the benefits described above, or that accommodation could be provided to allow access.

_____

_____

_____

A copy of the above form may be obtained by contacting the designated ADA coordinator identified at N.J.A.C. 2:1-4.4.

2:1-4.8 Investigation

(a) Upon receipt of a complaint submitted pursuant to this subchapter, the designated ADA coordinator will notify the complainant of the receipt of the complaint and the initiation of an investigation into the matter. The designated ADA coordinator will also indicate a date by which it is expected that the investigation will be completed, which date shall not be later than 45 days from the date of receipt of the complaint, unless a later date is agreed to by the complainant.

(b) Upon completion of the investigation, the designated ADA coordinator shall prepare a report for review by the designated decision maker for the agency. The designated decision maker shall render a written decision within 45 days of receipt of the complaint, unless a later date is agreed to by the complainant, which decision shall be transmitted to the complainant and/or the alternate contact person if so designated by the complainant.

BANKING

(a)

DIVISION OF REGULATORY AFFAIRS

Notice of Administrative Correction
Multiple Party Deposit Accounts
Specific Content of Deposit Contract
N.J.A.C. 3:1-12.4

Take notice that the Department of Banking has discovered an error in the current text of N.J.A.C. 3:1-12.4. The one-paragraph subsection (b) which was added to the rule effective February 4, 1991 (see 22 N.J.R. 3425(a) and 23 N.J.R. 294(b)) was mislocated within the rule upon its incorporation into the Code. Rather than appearing as the rule's second paragraph, subsection (b) should be the last paragraph of the rule. This notice of administrative correction is published pursuant to N.J.A.C 1:30-2.7.

Full text of the corrected rule follows (addition indicated in boldface **thus**; deletion indicated in brackets [thus]):

3:1-12.4 Specific content of deposit contract

(a) The following information must be included in all multiple-party account contracts:

[(b) Model forms may be found in Appendix A to this chapter, incorporated herein by reference.]

1.-5. (No change.)

(b) Model forms may be found in Appendix A to this chapter, incorporated herein by reference.

(b)

ADMINISTRATION

Disability Discrimination Grievance Procedure
Adopted New Rules: N.J.A.C. 3:3-3

Proposed: April 5, 1993 at 25 N.J.R. 1314(b).
Adopted: June 3, 1993 by Jeff Connor, Commissioner, Department of Banking.
Filed: June 7, 1993 as R.1993 d.321, **without change.**

Authority: N.J.S.A. 17:1-8.1, 42 U.S.C. 12101 et seq., and 28 C.F.R. 35.107.

Effective Date: July 6, 1993.
Expiration Date: January 11, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

SUBCHAPTER 3. DISABILITY DISCRIMINATION GRIEVANCE PROCEDURE

3:3-3.1 Definitions

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

"ADA" means the Americans with Disabilities Act, 42 U.S.C.A. §12101 et seq.

"Agency" means the New Jersey Department of Banking.

"Designated decision maker" means the Commissioner of Banking or his or her designee.

3:3-3.2 Purpose

(a) These rules are adopted by the agency in satisfaction of the requirements of the ADA and regulations promulgated pursuant thereto, 28 C.F.R. 35.107.

(b) The purpose of these rules is to establish a designated coordinator whose duties shall include assuring that the agency complies with and carries out its responsibilities under the ADA. Those duties shall also include the investigation of any complaint filed with the agency pursuant to N.J.A.C. 3:3-3.5 through 3.8.

3:3-3.3 Required ADA Notice

In addition to any other advice, assistance or accommodation provided, a copy of the following notice shall be given to anyone who inquires regarding the agency's compliance with the ADA or the availability of accommodation which would allow a qualified individual with a disability to receive services or participate in a program or activity provided by the agency.

AGENCY NOTICE OF ADA PROCEDURE

The agency has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by the U.S. Department of Justice regulations implementing Title II of the Americans with Disabilities Act. Title II states, in part, that "no otherwise qualified disabled individual shall, solely by reason of such disability, be excluded from participation in, be denied the benefits of or be subjected to discrimination" in programs or activities sponsored by a public entity.

Rules describing and governing the internal grievance procedure can be found in the New Jersey Administrative Code, N.J.A.C. 3:3-3. As those rules indicate, complaints should be addressed to the agency's designated ADA Coordinator, who has been designated to coordinate ADA compliance efforts, at the following address:

ADA Coordinator
Department of Banking
20 West State Street
CN 040
Trenton, New Jersey 08625

1. A complaint may be filed in writing or orally, but should contain the name and address of the person filing it, and briefly describe the alleged violation. A form for this purpose is available from the designated ADA coordinator. In cases of employment related complaints, the procedures established by the Department of Personnel, N.J.A.C. 4A:7-1.1 et seq. will be followed where applicable.

2. A complaint should be filed promptly within 20 days after the complainant becomes aware of the alleged violation. (Processing of allegations of discrimination which occurred before this grievance procedure was in place will be considered on a case-by-case basis).

3. An investigation, as may be appropriate, will follow the filing of a complaint. The investigation will be conducted by the agency's designated ADA Coordinator. The rules contemplate informal but thorough investigations, affording all interested persons and their representatives, if any, an opportunity to submit evidence relevant to a complaint.

4. In most cases a written determination as to the validity of the complaint and a description of the resolution, if any, will be issued by the designated decision maker and a copy forwarded to the complainant no later than 45 days after its filing.

5. The ADA coordinator will maintain the files and records of the agency relating to the complaints filed.

6. The right of a person to a prompt and equitable resolution of the complaint filed hereunder will not be impaired by the person's pursuit of other remedies such as the filing of an ADA complaint with the responsible Federal department or agency or the New Jersey Division on Civil Rights. Use of this grievance procedure is not a prerequisite to the pursuit of other remedies.

7. The rules will be construed to protect the substantive rights of interested persons, to meet appropriate due process standards and to assure that the agency complies with the ADA and implementing Federal rules.

3:3-3.4 Designated ADA coordinator

(a) The designated coordinator of ADA compliance and complaint investigation for the agency is:

ADA Coordinator
Department of Banking
20 West State Street
CN 040
Trenton, New Jersey 08625

(b) All inquiries regarding the agency's compliance with the ADA and the availability of accommodation which would allow a qualified individual with a disability to receive services or participate in a program or activity provided by the agency should be directed to the designated coordinator identified in (a) above.

(c) All complaints alleging that the agency has failed to comply with or has acted in a way that is prohibited by the ADA should be directed to the designated ADA coordinator identified in this section, in accordance with the procedures set forth in N.J.A.C. 3:3-3.5 through 3.8.

3:3-3.5 Complaint procedure

A complaint alleging that the agency has failed to comply with the ADA or has acted in a way that is prohibited by the ADA shall be submitted either in writing or orally to the designated ADA coordinator identified in N.J.A.C. 3:3-3.4. A complaint alleging employment discrimination will be processed pursuant to the rules of the Department of Personnel, N.J.A.C. 4A:7-1.1 through 3.4, if those rules are applicable.

3:3-3.6 Complaint contents

(a) A complaint submitted pursuant to this subchapter may be submitted in or on the form set forth at N.J.A.C. 3:3-3.7.

(b) A complaint submitted pursuant to this subchapter shall include the following information:

1. The name of the complainant, and/or any alternate contact person designated by the complainant to receive communication or provide information for the complainant;

2. The address and telephone number of the complainant or alternate contact person; and

3. A description of manner in which the ADA has not been complied with or has been violated, including times and locations of events and names of witnesses if appropriate.

3:3-3.7 Complaint form

The following form may be utilized for the submission of a complaint pursuant to this subchapter:

Americans with Disabilities Act Grievance Form

Date: _____

Name of grievant: _____

Address of grievant: _____

Telephone number of grievant: _____

Disability of grievant: _____

Name, address and telephone number
of alternate contact person:

_____

_____

Agency alleged to have denied access:

Department: _____

Division: _____

Bureau or office: _____

Location: _____

Incident or barrier:

Please describe the particular way in which you believe you have been denied the benefits of any service, program or activity or have otherwise been subject to discrimination. Please specify dates, times

and places of incidents, and names and/or positions of agency employees involved, if any, as well as names, addresses and telephone numbers of any witnesses to any such incident. Attach additional pages if necessary.

Proposed access or accommodation:

If you wish, describe the way in which you feel access may be had to the benefits described above, or that accommodation could be provided to allow access.

A copy of the above form may be obtained by contacting the designated ADA coordinator identified at N.J.A.C. 3:3-3.4.

3:3-3.8 Investigation

(a) Upon receipt of a complaint submitted pursuant to this subchapter, the designated ADA coordinator will notify the complainant of the receipt of the complaint and the initiation of an investigation into the matter. The designated ADA coordinator will also indicate a date by which it is expected that the investigation will be completed, which date shall not be later than 45 days from the date of receipt of the complaint, unless a later date is agreed to by the complainant.

(b) Upon completion of the investigation, the designated ADA coordinator shall prepare a report for review by the designated decision maker for the agency. The designated decision maker shall render a written decision within 45 days of receipt of the complaint, unless a later date is agreed to by the complainant, which decision shall be transmitted to the complainant and/or the alternate contact person if so designated by the complainant.

COMMUNITY AFFAIRS

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Notice of Administrative Correction
Uniform Construction Code
Asbestos Hazard Subcode
Effective Date; Variation Application Fee
N.J.A.C. 5:23-8.4

Take notice that the Department of Community Affairs has discovered two typographic errors in the notice of adoption for a new rule and repeals at and amendments to N.J.A.C. 5:23-8 published in the June 7, 1993 New Jersey Register at 25 N.J.R. 2519(b).

First, the "June 17, 1993" effective date for the new rule, repeals and amendments set forth in the notice heading at 25 N.J.R. 2519(a) should be **June 7, 1993,** the publication date for the notice of adoption, as set forth in the original notice document (see R.1993 d.198).

Second, the variation application fee of "$647.00" set forth at N.J.A.C. 5:23-8.4(c) at 25 N.J.R. 2532 should be "$467.00" as set forth in the original notice document.

This notice of administrative correction is published pursuant to N.J.A.C. 1:30-2.7.

Full text of the corrected rule follows (addition indicated in boldface **thus**; deletion indicated in brackets [thus]):

5:23-8.4 Variations

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

(c) When the Department is the enforcing agency, the fee for an application for a variation from this subchapter shall be [$647.00] **$467.00** and shall be paid by check or money order payable to "Treasurer, State of New Jersey."

(d) (No change.)

ENVIRONMENTAL PROTECTION AND ENERGY

(b)

ENVIRONMENTAL PROTECTION AND ENERGY ENFORCEMENT

Notice of Administrative Correction
Water Pollution Control Act
Civil Administrative Penalties and Requests for Adjudicatory Hearings
Financial Assurance Requirements
N.J.A.C. 7:14-8.4

Take notice that the Department of Environmental Protection and Energy (Department) has become aware of an error in N.J.A.C. 7:14-8.4(a)9ii that is apparent to the Department and to the regulated public, and is correcting the error through this notice of administrative correction.

N.J.A.C. 7:14-8.4 establishes the procedure for requesting an adjudicatory hearing to contest a penalty assessed pursuant to N.J.A.C. 7:14-8 for violations of the Water Pollution Control Act, N.J.S.A. 58:10A-1 et seq. Unless the person contesting the penalty is a local agency (as defined in N.J.A.C. 7:14-8.2), that person must include the following with the hearing request:

i. Financial assurance, in the form of a surety bond guaranteeing payment, an irrevocable letter of credit or a fully funded trust, worded identically to the wording specified in N.J.A.C. 7:14-8 Appendix D or in another form the Department individually approves in writing for this purpose; and

ii. A certification of acknowledgment worded identically to the wording specified in N.J.A.C. 7:14-8 Appendix D.

Several members of the regulated public have pointed out that the language of the Certification of Acknowledgment makes it clearly unsuitable when the financial assurance is in the form of a letter of credit. The Certification of Acknowledgment concerns the execution of the financial assurance document by the person contesting the penalty; however, the letter of credit would be executed only by the issuing institution, and not by the person contesting the penalty. Accordingly, the Department is correcting N.J.A.C. 7:14-8.4(a)9ii to no longer require a certification of acknowledgment when the financial assurance is in the form of a letter of credit.

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

7:14-8.4 Procedures to request an adjudicatory hearing to contest an administrative order, a notice of civil administrative penalty assessment or a notice of civil administrative cost assessment; procedures for conducting adjudicatory hearings

(a) To request an adjudicatory hearing to contest an administrative order, a notice of civil administrative penalty assessment, or a notice of civil administrative cost assessment issued pursuant to the Water Pollution Control Act, the New Jersey Underground Storage of Hazardous Substances Act, the Water Supply and Wastewater Operator's Licensing Act, or the Water Supply Management Act, the violator shall submit the following information in writing to the Department at Office of Legal Affairs, ATTENTION: Adjudicatory Hearing Requests, Department of Environmental Protection and Energy, CN 402, Trenton, New Jersey 08625-0402:

1.-8. (No change.)

9. If the violator is not a local agency, financial assurance in the full amount of the civil administrative penalty in the notice of civil administrative penalty assessment as follows:

i. (No change.)

ii. **Unless the financial assurance is in the form of a letter of credit,** [A]**a** certification of acknowledgment worded identically to the wording specified in N.J.A.C. 7:14-8 Appendix D.

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

(a)

DIVISION OF SOLID WASTE MANAGEMENT

Used Motor Oil Recycling Rules

Adopted New Rules: N.J.A.C. 7:26A-6

Adopted Amendments: N.J.A.C. 7:26-7.7 and 8.20

Proposed: July 6, 1992 at 24 N.J.R. 2383(a).

Adopted: June 11, 1993 by Jeanne M. Fox, Deputy Commissioner, Department of Environmental Protection and Energy.

Filed: June 14, 1993 as R.1993 d.342, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 13:1E-1 et seq., specifically 13:1E-6, 13:1E-99.35 and 13:1E-99.36.

DEPE Docket Number: 24-92-06.

Effective Date: July 6, 1993.

Expiration Date: November 18, 1996.

Summary of Public Comments and Agency Responses:

The New Jersey Department of Environmental Protection and Energy (Department) is adopting new rules, N.J.A.C. 7:26A-6, to implement sections of the New Jersey Statewide Mandatory Source Separation and Recycling Act, N.J.S.A. 13:1E-99.11 et seq. (Mandatory Recycling Act). Pursuant to the Mandatory Recycling Act, the Department will regulate used motor oil collection and recycling activities at used oil collection centers and sign posting requirements for motor oil retailers.

The proposed new rules were published in the New Jersey Register at 24 N.J.R. 2383(a) on July 6, 1992. Secondary notice was given by publishing notices in 10 newspapers of general circulation and by mailing the full text of the proposal to 33 potentially affected facilities and other interested parties. Written comments were received from 13 persons during the public comment period, which closed on September 4, 1992. A public hearing was held on July 29, 1992, in Trenton, New Jersey.

Five persons presented comments at the public hearing. The following persons presented written comments and/or made oral comments at the public hearing:

(A) John Holtz, Associate Director, New Jersey Petroleum Council

(B) Carl Gerster, Manager of Used Oil Ventures, Mobil Oil Corporation

(C) Dr. Norman Jacobson, Director of Environmental Health and Safety, Castrol, Incorporated

(D) Edward Hogan, Attorney, Porzio, Bromberg and Newman

(E) Wayne DeFeo, Manager of Business Development and Internal Affairs, Browning-Ferris Industries

The following persons submitted written comments:

(1) F.M. Anderson, Exxon Company, U.S.A.

(2) David Black, Black & Associates

(3) Renee Gast, New Jersey Association of Plumbing-Heating-Cooling Contractors, Inc.

(4) Georgia Hartnett, Elizabethtown Gas Company

(5) Curt Macysyn, Fuel Merchants Association of New Jersey

(6) Sarosh Manekshaw, Pennzoil Company

(7) Barbara Price, Phillips Petroleum Company

(8) Joe Reichwein, Rapid Service Garage

(9) Larry Schmidt, resident of New Jersey

(10) James Shissias, Public Service Electric & Gas Company

A total of 28 comments were received from the public. The comments and the Department's responses follows, with the appropriate commenter's assigned letter or number indicated in parentheses after each comment.

N.J.A.C. 7:26A-6.2 Definitions

Used oil collection center

1. COMMENT: Two commenters noted that the definitions of "used oil collection center" found at N.J.A.C. 7:26A-6.2 would include *any* private inspection center licensed by the Division of Motor Vehicles. Many New Jersey corporations which operate 10 or more fleet vehicles in support of their business operations are licensed as private inspection centers, solely for the purpose of inspecting their own vehicles, under N.J.S.A. 39:8-14. Is it the intent of the Department to regulate these types of inspection stations by requiring them to accept used motor oil from the general public? The commenters recommended that the definition be limited to those gas stations and service stations currently regulated under N.J.S.A. 39:8-11. (4,10)

RESPONSE: It is not the intent of the Department to regulate the owner or lessee of 10 or more vehicles licensed as a private inspection center under N.J.S.A. 39:8-14. Therefore, the Department is amending the definition of "used oil collection center" at N.J.A.C. 7:26A-6.2 to exclude those private inspection centers licensed under N.J.S.A. 39:8-14.

N.J.A.C. 7:26A-6.3 Restrictions

2. COMMENT: N.J.A.C. 7:26A-6.3(b) should be amended to allow for the use of tanks with waste oil separation devices, by inserting the following language at the end of the subsection: "except in the case of a waste oil tank when used with an approved waste oil separation device." (3)

RESPONSE: The commenter is concerned that service stations or private inspection centers with floor drains connected to oil-water separation devices, which send waste oil to the used oil collection tank and waste water to the sewer system, may be in violation of these rules should the oil-water separator not perform perfectly and allow water to enter the used oil collection tank. It is not the intent of the section either to regulate this type of activity or to prohibit the use of oil-water separation devices which may be required by other regulations. Rather, this section prohibits only the direct and intentional discharge of contaminants into used oil collection tanks and the direct and intentional mixing of contaminants with used motor oil in containers that are then delivered to a used oil collection center for recycling. Therefore, the Department does not believe that the recommended change is needed.

3. COMMENT: How will N.J.A.C. 7:26A-6.3 be enforced and what penalties will apply? This section should be amended to allow a person who operates a used oil collection center to refuse to accept any used oil that he or she suspects is contaminated. (A)

4. COMMENT: These regulations prohibit the public from contaminating used oil with a hazardous waste. However, if the public ignores these regulations, the collection facility still bears the liability risk and additional costs associated with the proper handling and disposal of a truly hazardous material, one which it did not even generate. These proposed regulations should contain a section providing for the reimbursement to the collection facility of the additional costs associated with a "hot" (contaminated) load. (B)

RESPONSE: N.J.A.C. 7:26A-6.9 states that the Department shall enforce the provisions of this proposed subchapter in accordance with the Solid Waste Management Act, N.J.S.A. 13:1E-1 et seq., including the issuance of civil administrative penalties, as provided in the Division of Solid Waste Management regulations at N.J.A.C. 7:26-5.5. County health departments and local boards of health also have the authority to enforce these rules in accordance with N.J.S.A. 13:1E-9. The Department is modifying N.J.A.C. 7:26A-6.3 to clarify that these rules do not require the owner or operator of a used oil collection center to accept used motor oil which he or she reasonably suspects to contain water, antifreeze, industrial waste or any other contaminant. Low-cost means of detecting contamination are currently available. It is the intent of the Department to place the responsibility for determining whether the used motor oil is contaminated on the used oil collection center. Therefore, while a used oil collection center may refuse to accept used motor oil that is *reasonably* believed to be contaminated, ultimately, the used oil collection center shall be considered the generator of any used oil that it handles.

N.J.A.C. 7:26A-6.4 Labeling of motor oil containers

5. COMMENT: N.J.A.C. 7:26A-6.4 should be amended to include the phrase "or similar statement approved by the Department" after the words "following statement." This change is needed to provide companies the flexibility to print labels for nationwide distribution. (1)

6. COMMENT: Several commenters noted that the statement proposed in the labeling provision at N.J.A.C. 7:26A-6.4 requires a variation of the labeling already required by the Federal Used Oil Recycling Act of 1980, 42 U.S.C. 6914(a). Due to market trading areas, oil products are packaged for distribution throughout the United States and are not earmarked for distribution to specific states. In addition, many manufacturers use in-mold labeling, where the label is actually part of the bottle, rather than affixed labels. In these cases, adhering to the regulations would not simply be a matter of using up the existing stock of labels and printing new ones, but rather would involve developing a specific label and/or bottle for each state with differing labeling requirements, and then filling, segregating, storing and shipping the containers to the appropriate destinations. Thus, complying with the respective State and Federal labeling requirements would result in a tremendous administrative burden. Additionally, significant constitutional preemption arguments militate against the adoption of the proposed New Jersey labeling requirement. (A,B,C,D,5,6,7)

7. COMMENT: Several commenters suggested that the 180 days allowed for compliance with the labeling requirements at N.J.A.C. 7:26A-6.4(a) be extended to either 270 days or one year, due to the complicated task of making changes to existing labels. (A,C,6)

8. COMMENT: Two commenters questioned the legality of including the sentence "Used motor oil is recyclable" in the labeling requirement at N.J.A.C. 7:26A-6.4. The definition of "recyclable" is controversial, and several states have laws defining how this term may be used in those states. The addition of the sentence "Used motor oil is recyclable" to motor oil labels may be in violation of existing rules in neighboring states, and may also be contrary to the guidelines of the Federal Trade Commission, issued on August 13, 1992, regarding the use of environmental marketing claims concerning the term "recyclable." (C,6)

RESPONSE: The Department agrees with the commenters that the proposed language, which differs from the Federally mandated language, would be overly burdensome to manufacturers of motor oil products given the complexities of the distribution system and the problems associated with state-specific language. Therefore, the Department is modifying N.J.A.C. 7:26A-6.4 to make it consistent with the language required by the Federal Used Oil Recycling Act of 1980, 42 U.S.C. 6914(a).

N.J.A.C. 7:26A-6.5 Posting requirements

9. COMMENT: Several commenters questioned the need to specify "metal" signs in N.J.A.C. 7:26A-6.5(a) and 6.5(b). The information on the required signs, such as the collection fee, if any, may change from time to time, and unless the sign is going to be posted outdoors, a metal sign seems to be an unreasonable requirement. The majority of the oil companies have developed signs for their collection programs which convey a message similar to the one proposed for New Jersey. These signs are usually made available free of charge to the retailer or collection site. Several commenters suggested that other materials of similar durability, such as plastic or heavy cardboard, be allowed. (A,B,C,D,1,6,7)

10. COMMENT: The posting requirements for motor oil retailers at N.J.A.C. 7:26A-6.5(a)1 and for used oil collection centers at N.J.A.C. 7:26A-6.5(b)1 should be deleted. The detailed instructions regarding display of the signs are unnecessary and may pose logistical difficulties, as every location will be different. (D,1)

11. COMMENT: The proposed regulations at N.J.A.C. 7:26A-6.5(b) provide that used oil collection centers post required signs with an "unobstructed view." The regulations would be sufficient if they provided that a sign be conspicuously displayed both in the retail center and on the outside wall of a collection center. (A,D)

RESPONSE: Pursuant to N.J.S.A. 13:1E-99.36, the Mandatory Recycling Act specifies the posting of a "durable and legible metal sign not less than 11 inches by 15 inches in size," by motor oil retailers as well as used oil collection centers. The statute does not allow for the use of other materials in lieu of metal; such a change would require a statutory amendment. In addition, the Department has found that while some in the oil industry have certainly made efforts to encourage the recycling of used motor oil, including the development of signs conveying the recycling message, this is the exception, rather than the rule. There is a real need for consistent state-wide sign requirements, to avoid confusion on the part of the public. The Department believes that the sign posting requirements as proposed in N.J.A.C. 7:26A-6.5 allow for sufficient flexibility: for example, motor oil retailers may suspend the sign from the ceiling or affix it to a wall, shelf or free-standing display. The height requirements are intended to ensure that motor oil retailers and used oil collection centers post signs containing important information regarding used motor oil collection and recycling in locations which are easily visible to the general public.

N.J.A.C. 7:26A-6.6 Collection requirements and quantity limitations

12. COMMENT: It would be helpful to collection centers if this section were expanded to clarify that containers used to transport used oil by the public to collection centers may be discarded as solid waste once the container is emptied if only trace amounts of the used oil remain. (A)

RESPONSE: The Department agrees with the commenter that clarification of the status of emptied containers which were used to transport the used motor oil to the used oil collection center would be helpful. The Department is modifying N.J.A.C. 7:26A-6.6 to indicate that these empty containers may be disposed of as solid waste pursuant to N.J.A.C. 7:26-8.4.

13. COMMENT: Most families have two cars, and some cars have a crankcase capacity greater than five quarts. For example, Mercedes-Benz automobiles have a crankcase of seven to eight quarts. The quantity limitation would require some consumers to make two trips, on separate days, to the collection center to deliver their used oil. The Department should increase the quantity that collection centers can accept from each consumer to five gallons (20 quarts) per day to provide a collection service for all consumers, even those with large crankcases, and to be consistent with collection requirements in other states, many of which have adopted the five gallon quantity limitation. (6)

14. COMMENT: As a do-it-yourselfer, I recommend that an individual be permitted to drop off at least 16 quarts of waste oil per day. Ten quarts at a time is too little. I personally store waste oil in four or five gallon jugs and take them to the gas station when all are full, about twice a year. (9)

RESPONSE: The Department has determined that the proposed 10 quart limit should be adequate to meet the needs of the typical two-car family, and will accommodate the used oil generated by changing the oil and draining the filters from both cars. While Mercedes-Benz automobiles may have a crankcase capacity in excess of five quarts, the Department finds that the majority of cars have crankcase capacities of less than five quarts. In addition, the 10 quart limit will encourage do-it-yourselfers to recycle their oil immediately after generating it, rather than storing it for extended periods of time. This policy will decrease the risk of a spill or leak. As a practical matter, the 10 quart limit should decrease the incidence of contaminants being mixed with used motor oil prior to recycling, as a 10 quart jug will hold approximately two oil changes, leaving little room for other materials which may contaminate the oil. Persons using a four or five gallon jug or pail, on the other hand, may find that there is extra room in the jug after depositing the used oil and may attempt to dispose of other household chemicals along with the oil. Finally, it should be noted that the rule does allow the owner or operator of a used oil collection center to accept, at his or her discretion, more than 10 quarts of used oil per person per day. See N.J.A.C. 7:26A-6.6(a) and N.J.A.C. 7:26A-6.5(b)2.

N.J.A.C. 7:26A-6.7 Management and transfer of used oil by used oil collection center

15. COMMENT: Several commenters indicated that they support the Department's goal of fostering used oil recycling, but do not believe that the goal of increased recycling will be satisfied by continuing to subject collected used oil to hazardous waste regulation. New Jersey's current approach to used oil is inconsistent with the determinations of the U.S. Environmental Protection Agency and most other states. Several commenters suggested that the Department provide either management standards for used motor oil in lieu of the hazardous designation or a special nonhazardous designation for used oil accepted from the public. The designation of used oil as hazardous waste will result in fewer gallons of used oil being recycled and increased illegal dumping activity. (A,B,C,E,1,6,7)

RESPONSE: It is beyond the scope of these rules to address the issue of whether or not used motor oil should be subject to regulation as hazardous waste in New Jersey. The modification to N.J.A.C. 7:26-8.20 contained in this proposal is for purposes of clarification and consistency only, and does not alter the manner in which used motor oil must be handled in New Jersey. The Department is aware of the historical discussions over the manner in which used oil should be regulated, that is, as a hazardous or non-hazardous waste, and is currently in the process of developing a preproposal which will solicit comments on a range of issues related to used oil transportation and management. It is antici-

pated that this preproposal will be published in the New Jersey Register within the next six to 12 months. At that time, the public will have the opportunity to comment on the existing system of used oil management, and to address the issue of whether or not used oil should continue to be regulated as a hazardous waste.

16. COMMENT: Is it the intent of these proposed regulations to broaden the small quantity generator definition to provide 1,001 gallon exemptions to used oil collection centers? If so, should these exemptions be written into the regulations? Will other generators also benefit? (2)

RESPONSE: It is not the intent of these rules to broaden the small quantity generator requirements, but to clarify the regulatory status of used oil collection centers which collect used oil from consumers. The exemption from certain generator requirements for generators who meet specified requirements is contained in the Hazardous Waste Regulations, at N.J.A.C. 7:26-7.7. N.J.A.C. 7:26-7.7(c) has been modified with this adoption to specifically exempt used oil collection centers, as defined at N.J.A.C. 7:26A-6.2, with on-site storage capacity of less than 1,001 gallons, from manifesting requirements. This modification will allow all used oil collection centers, whether automotive service stations or municipally or county-sponsored sites, to promote used motor oil recycling programs for residentially-generated used motor oil, without being subject to the hazardous waste generator responsibilities at N.J.A.C. 7:26-7.4, provided that they comply with N.J.A.C. 7:26-7.7(d). Without the addition of this exemption provision, municipally and county-sponsored used oil collection centers would be limited to accepting less than 1,001 gallons of used motor oil per month, as per N.J.A.C. 7:26-7.7(b), in order to meet the requirements for an exemption from the generator requirements at N.J.A.C. 7:26-7.4. This situation would have penalized the municipally and county-sponsored sites, and would have been detrimental to the ongoing efforts to increase the amount of used motor oil that is collected for recycling. This new exemption, consistent with the existing exemptions at N.J.A.C. 7:26-7.7(b) and (c), is applicable only to used oil collection centers which do not generate fully regulated amounts of other (non-waste oil) hazardous wastes.

17. COMMENT: The summary states, "Used oil collection centers will be required to manifest the waste oil, unless one of the exemptions at N.J.A.C. 7:26-7.7 is applicable." N.J.A.C. 7:26-7.7 is applicable only to "the original generator." Is it the intent of the proposed regulations to include in the definition of original generators, used oil collection centers? If so, then N.J.A.C. 7:26A-6.7(a) should state, "The used oil collection center is considered an 'original generator' of hazardous waste under N.J.A.C. 7:26-7." If it is not the intent of these proposed regulations to define used oil collection centers as original generators, then these collection activities will never qualify for the exemption. Thus, all references to the exemption should be omitted from the proposal, and N.J.A.C. 7:26A-6.7(b) should state, "An owner or operator of a used oil collection center will not qualify as an original generator for an exemption from the requirements to initiate a hazardous waste manifest for the waste oil, and must manifest the waste in accordance with N.J.A.C. 7:26-7.4." (2)

18. COMMENT: Proposed N.J.A.C. 7:26A-6.7(a) would mandate that any used oil accepted from the public not only is already a hazardous waste, but that the collection center is also then considered the "generator" of that waste. These regulations should be amended to delete the automatic generator designation for the collection facility. (B)

RESPONSE: Used oil collection centers are considered "generators," as defined at N.J.A.C. 7:26-1.4, of hazardous waste oil type X721, and are subject to hazardous waste regulation. The Department disagrees with the comment that the generator designation for used oil collection centers should be deleted. Used oil collection centers, such as retail service stations, private inspection centers, or municipal public works yards, which are generating waste oil as a normal part of their operations, already qualify as "generators" under N.J.A.C. 7:26-1.4, and are subject to the generator requirements at N.J.A.C. 7:26-7. The fact that such operations also accept used motor oil from the public does not alter their generator status. Although used motor oil which is generated by a resident who changes his or her own oil qualifies for the household waste exclusion, under N.J.A.C. 7:26-8.2(a)6, if that oil is mixed with waste oil type X721, which does not originate at the household level, the entire load of oil is considered to be hazardous waste. The possibility exists that a used oil collection center would be set up with a tank intended exclusively for the collection of used motor oil generated by residents, that is, a municipal recycling depot which does not accept used motor oil generated by the municipal vehicles (police cars, public works vehicles, etc.). However, these sites are generally left unattended, and there is no way to guarantee that the used oil deposited in such tanks comes solely from residents, and not from businesses. Therefore, in order to provide a uniform management system for used oil, all used oil collection centers are considered "generators" and are subject to hazardous waste regulation. The Department is, in effect, limiting the household waste exclusion found at N.J.A.C. 7:26-8.2(a)6, in its applicability to used motor oil. The Department believes that this approach is the least burdensome to the regulated community, and will ensure that used motor oil is handled in a consistent and environmentally sound manner.

19. COMMENT: Is it the intent of these proposed regulations to exempt a used oil collection center from hazardous waste facility requirements?

RESPONSE: It is not the intent of these regulations to exempt a used oil collection center from hazardous waste facility requirements. If a used oil collection center accumulates more than 1,001 gallons of used motor oil at any one time, that used oil collection center would be subject to the regulatory requirements for hazardous waste facilities set forth at N.J.A.C. 7:26-9.

20. COMMENT: In addition to administrative and regulatory relief, an exemption from potential Superfund liability would encourage facilities to become used oil collection centers. This exemption would protect facilities that meet all of the used motor oil recycling rules from a future liability and relieve them of the possible associated property value reduction. (6)

RESPONSE: The commenter has requested an exemption from potential liability under a Federal statute, the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), commonly known as the Superfund law. The Department, as a State agency, lacks the jurisdiction to modify CERCLA, a Federal statute. Any modifications to a Federal statute must occur at the Federal level. However, Section III(B)(7) of the preamble to the U.S. Environmental Protection Agency's (EPA's) final rule promulgating standards for the management of used oil under RCRA section 3014, dated September 10, 1992, discusses CERCLA liability. This section states that, "Section 114(c) of CERCLA contains the service station dealer's exemption from liability under the statute for used oil. To be eligible for the exemption, service stations are required to comply with the section 3014 of RCRA used oil management standards and accept (do-it-yourselfer)-generated used oil."

Section IX(D) of the preamble further discusses the relationship of EPA's final rule to CERCLA, as follows: "Section 104 of CERCLA authorizes the Federal government to respond to any release or substantial threat of a release into the environment of any hazardous substance and any release or threatened release of a pollutant or contaminant that may present an imminent and substantial danger to public health. Section 101(14) defines the term 'hazardous substance' and Section 101(33) defines 'pollutant or contaminant.' Both of these definitions expressly exclude 'petroleum, including crude oil or any fraction thereof' unless a petroleum waste has been specifically listed under RCRA or other environmental statutes. The Agency has interpreted the petroleum exclusion to include crude oil and fractions of crude oil, including hazardous substances that are indigenous in petroleum substances. However, hazardous substances that are added to petroleum or that increase in concentration solely as a result of contamination of the petroleum are not part of the petroleum and thus are not excluded. Therefore, used oil that contains a hazardous substance due to contamination is subject to CERCLA reporting, response, and liability provisions."

N.J.A.C. 7:26A-6.8 Reporting requirements

21. COMMENT: N.J.A.C. 7:26A-6.8 should be deleted. This type of requirement is a disincentive for voluntary programs that have been implemented by Exxon and other American Petroleum Institute member companies. In addition, the current hazardous waste tracking system in New Jersey already provides this data. (A,1)

22. COMMENT: The reporting requirements in N.J.A.C. 7:26A-6.8 specify that semi-annual collection reports must be submitted to the Department. Many small businesses may be discouraged from volunteering as a used oil collection center if the administrative burden is too great. In light of this, Pennzoil recommends that the Department require reports to be submitted only once a year. (6)

RESPONSE: The Department agrees that the more accurate method of obtaining data on used oil collection activity would be through the existing hazardous waste manifest system. Therefore, the Department has deleted N.J.A.C. 7:26A-6.8 in its entirety. The Department disagrees

with the commenters' reasoning with regarding to "voluntary" programs. In New Jersey, any retail service station or private inspection center with a used oil collection tank on the premises is required to accept used motor oil from the public under the Mandatory Recycling Act. N.J.S.A. 13:1E-99.36. While used oil collection programs sponsored by major oil companies may be voluntary in other states, participation by such businesses as used oil collection centers in New Jersey is mandatory.

N.J.A.C. 7:26A-6.10 Penalties

23. COMMENT: The Fuel Merchants Association commented that the rules should include penalty provisions for the improper disposal of used motor oil. The Department should have the ability to levy fines against any person who improperly discards or disposes of used motor oil, including anyone who contaminates used oil prior to disposing of it at a recycling center. (5)

RESPONSE: N.J.A.C. 7:26A-6.10 invokes the penalty provisions of N.J.S.A. 13:1E-9, as implemented by N.J.A.C. 7:26-5. The penalties are applicable to used oil collection centers as well as any person who improperly disposes of used motor oil or who contaminates used motor oil prior to recycling it at a used oil collection center.

Miscellaneous Comments

24. COMMENT: Several commenters noted that allowing used oil collection centers to charge customers for accepting their used oil creates a financial disincentive for consumers to properly dispose of their oil. Most do-it-yourselfers change their own oil in order to save money. Therefore, it is highly unlikely that a do-it-yourselfer will be willing to pay some unspecified fee to dispose of used oil when illegal means of disposal are available at no charge (that is, dumping). In addition, allowing the fee to vary between collection centers means that those collection centers that do not want to accept used oil can set the fee as high as possible, thereby discouraging consumers from dropping off their oil there. The proposed system is counterproductive. (A,B,D)

25. COMMENT: Two commenters noted that the flexibility to charge a fee for disposal of used motor oil must remain intact in the final regulations. The State is requiring many independent marketers to provide a public service by accepting used oil from the public. If there is no ability to recoup costs, there may be no incentive to remain a used oil collection center when costs become prohibitive. This may lead to a shortage of used oil collection centers. Those collection centers that do not have costs to recoup could provide the service at no charge, while others that do have costs to recoup could pass those charges on to their customers. (5,8)

RESPONSE: Allowing used oil collection centers to recoup their costs for accepting used motor oil from the public is not prohibited by statute. Furthermore, the enabling legislation did not grant the Department rate-setting authority with regard to this issue. The Department believes these charges should reflect the actual costs to used oil collection centers of implementing the regulations and should not be so high as to be a disincentive to consumers who bring their used motor oil to used oil collection centers. Further, excessive charges would be contrary to the statutory intent of N.J.S.A. 13:1E-99.35 and 36 to foster the recycling of used motor oil. The Department reserves the right to modify these regulations after one year, if it determines that used oil collection centers are charging excessive fees. Information gathered by the Department from municipal recycling coordinators indicates that the costs of collection of used motor oil generally range from $0 to $.25 per gallon. These costs vary depending on the time of year, the distance traveled by the hazardous waste transporter to the used oil collection center, and the price of crude oil.

26. COMMENT: The Social Impact section of the Summary presents an oversimplification of potentially complex issues, by indicating that the proposed rules will have a nominal social impact on motor oil retailers, licensed private inspection centers and retail service stations with an active used oil collection tank on the premises. The existence of an active used oil collection tank on the premises should not imply an obligation to serve the public at large. The unilateral creation of such an obligation places an undue burden on small businesses. By way of example, a service station which unknowingly accepts contaminated used motor oil from a consumer may be faced with unexpected and burdensome costs for disposing of such material. (D)

RESPONSE: The requirement that any retail service station or private inspection center with a used oil collection tank on the premises accept used motor oil from the public is contained in the Mandatory Recycling Act. N.J.S.A. 13:1E-99.36. A statutory amendment would be necessary to eliminate this requirement.

27. COMMENT: Anyone who sells motor oil at the retail level should be required to be a used oil collection center. In addition, used oil collection centers should be required to collect as many gallons of oil as are sold by the outlet at the retail level. For every quart sold, a corresponding quart should be collected and recycled. It makes environmental and economic sense to dispose of used motor oil at the outlet where it was purchased. Retailers of motor oil should have the obligation to see that the oil is properly disposed. (5)

28. COMMENT: Why are supermarkets not required to accept used motor oil? This aspect of the regulations is all wrong and unfair. (8)

RESPONSE: The requirement that motor oil retailers post signs informing the public of the importance of the proper collection and disposal of used oil is contained in the Mandatory Recycling Act at N.J.S.A. 13:1E-99.35. The statute did not require motor oil retailers to serve as used oil collection centers. In enacting the statute, the Legislature clearly did not intend to include supermarkets as used oil collection centers. A statutory amendment would be necessary to change these requirements.

Summary of Hearing Officer's Recommendations and Agency Responses:

Steven Gabel, Director of the Division of Solid Waste Management in the Department, served as Hearing Officer at the public hearing. The hearing was held on July 29, 1992 at the NJDEPE Public Hearing Room, 401 East State Street, Trenton, New Jersey. The hearing was held to provide interested persons the opportunity to present oral and/or written comment on the proposed rules.

After reviewing the comments offered at the public hearing, Mr. Gabel found that the Department's responses adequately addressed the concerns raised by the public. These responses to oral and written comments are set forth in the Summary of Public Comments and Agency Responses for this rule adoption. Mr. Gabel recommends that the Department carefully examine the rules in light of the public comments received at the hearing, and to make changes to the rules as necessary to address the public's concerns.

A copy of the record of the public hearing, which includes the Hearing Officer's Report, is available upon payment of the Department's normal charges for copying. Persons requesting copies should contact:

Janis Hoagland, Esq.
Department of Environmental Protection and Energy
Office of Legal Affairs
401 East State Street
CN 402
Trenton, NJ 08625

The Department accepts the recommendations of the Hearing Officer. In addition, based upon written comments which the Department received and its internal review of the rules, the Department has made changes from the proposal as described below. Cross references to the comment and response portion of this document are provided and agency initiated changes to the rules on adoption are explained.

Summary of Changes Upon Adoption:

Hazardous Waste Regulations

N.J.A.C. 7:26-7.7(c): The Department has added the following language before the word "automotive": "Used oil collection centers, as defined in N.J.A.C. 7:26A-6.2, with on-site storage capacity of less than 1,001 gallons, and." This modification will allow all used oil collection centers, whether retail service stations or municipally or county-sponsored sites, to promote used motor oil recycling programs for residentially generated used motor oil, without being subject to the hazardous waste generator requirements at N.J.A.C. 7:26-7.4, provided that they comply with N.J.A.C. 7:26-7.7(d).

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N.J.A.C. 7:26A-6.2 "Used oil collection center": The Department has added the phrase, "except those private inspection centers licensed at N.J.S.A. 39:8-14," after the word "Safety," in order to clarify the intent of these rules.

N.J.A.C. 7:26A-6.3(c): The Department has added the following provision, to clarify the intent of these rules: "Nothing in this subchapter shall require the owner or operator of a used oil collection center to accept used motor oil which the owner or operator reasonably suspects to contain water, antifreeze, industrial waste or any other contaminant."

N.J.A.C. 7:26A-6.4: The Department has inserted the word "immediately" in place of the phrase "(the date 180 days after effective date to be inserted)," and has modified the required label language to

be consistent with Federally mandated language. The sentence, "Used motor oil is recyclable" has been deleted, and the phrase "a collection center" has been changed to the plural form.

N.J.A.C. 7:26A-6.5(b): The Department has added the following provision as N.J.A.C. 7:26A-6.5(b)2: "At his or her discretion, the owner or operator of a used oil collection center may accept more than 10 quarts of used motor oil per person per day, in which case he or she shall change the sign accordingly, to reflect the increased limit."

N.J.A.C. 7:26A-6.6: This section has been broken into two subsections, as follows: N.J.A.C. 7:26A-6.6(a) addresses quantity limitations; N.J.A.C. 7:26A-6.6(b) addresses disposal requirements for containers used to transport used motor oil to collection centers. The sentence beginning with "Once emptied" has been recast in the active voice, and now reads, "The owner or operator of a used oil collection center may return the container used to transport used motor oil, once emptied, to the consumer at the discretion of the owner or operator or upon consumer demand." In addition, the following sentence has been added after the words, "upon consumer demand," in order to clarify disposal requirements for containers used to transport used motor oil to collection centers: "Alternatively, the owner or operator of the used oil collection center may dispose of the container as non-hazardous waste, in accordance with N.J.A.C. 7:26-8.4."

N.J.A.C. 7:26A-6.7(a): The words "or she" have been added after the word "he" for consistency in subsection (b). Subsection (c) has been added to clarify the application of hazardous waste regulations to used oil collection centers: "A used oil collection center that accumulates more than 1,001 gallons of waste oil X721 at any one time is subject to the regulatory requirements applicable to hazardous waste facilities at N.J.A.C. 7:26-9."

N.J.A.C. 7:26A-6.8: The Department has deleted this section in its entirety for the reasons explained in the response to Comment Nos. 21 and 22 in the Summary of Public Comments and Agency Responses above.

N.J.A.C. 7:26A-6.9 and 6.10: These sections have been recodified as N.J.A.C. 7:26A-6.8 and 6.9.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated by brackets with asterisks *[thus]*).

7:26-7.7 Exemption from manifest rules

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

(c) *[Automotive]* ***Used oil collection centers, as defined in N.J.A.C. 7:26A-6.2, with on-site storage capacity of less than 1,001 gallons, and automotive*** service stations which generate only hazardous waste with hazardous waste numbers X721, X722, X723, X724, X726, or X727 are exempted from the generator requirements as contained in N.J.A.C. 7:26-7.4 provided they comply with (d) below.

(d)-(e) (No change.)

7:26-8.20 State hazardous waste from non-specific sources

(a) State hazardous wastes from non-specific sources are as follows:

	NJ Hazardous Waste Number	Hazardous Waste	Hazardous Code
Generic	1. X721	Waste automotive crankcase and lubricating oils from automotive service and gasoline stations, truck terminals, garages, and used oil collection centers as defined at N.J.A.C. 7:26A-6.2.	(T)

2.-7. (No change.)

(b) (No change.)

SUBCHAPTER 6. USED MOTOR OIL

7:26A-6.1 Scope and purpose

This subchapter is intended to implement the used motor oil recycling provisions of N.J.S.A. 13:1E-99.35 and 99.36. These rules will enable residents of New Jersey to recycle used motor oil generated in a typical residential setting. Motor oil retailers will be required to inform the public at the point of purchase of the importance of recycling used motor oil, and collection centers will be required to identify themselves as a collection point for used motor oil recycling.

7:26A-6.2 Definitions

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

"Consumer" means any New Jersey resident who uses or purchases lubricating or other automotive oil for personal use, or who generates used motor oil through personal use of lubricating or other automotive oil.

"Designated county or municipal recycling coordinator" means any individual who has been designated in accordance with N.J.S.A. 13:1E-99.13 or N.J.S.A. 13:1E-99.16, respectively, to implement the "New Jersey Statewide Mandatory Source Separation and Recycling Act," N.J.S.A. 13:1E-99.11 et seq.

"Motor oil retailer" means any person who annually sells to consumers more than 500 gallons of lubricating or other automotive oil in containers for use off the premises where sold.

"Retail service station" means any person whose on-going automotive maintenance and/or repair business entails the removal and/or replacement of automotive lubricating oils.

"Used motor oil" means a petroleum based or synthetic oil whose use includes, but is not limited to, lubrication of internal combustion engines, which through use, storage or handling has become unsuitable for its original purpose due to the presence of impurities or loss of original properties.

"Used oil collection center" means any private inspection center licensed by the Division of Motor Vehicles in the Department of Law and Public Safety, ***except those private inspection centers licensed pursuant to N.J.S.A. 39:8-14,*** retail service station which has an active used oil collection tank on the premises, or any site which accepts used motor oil for recycling.

"Used oil collection tank" means any stationary device which is constructed of non-porous materials which provide structural support, whether above or below ground, in which used oil is stored.

7:26A-6.3 Restrictions

(a) No person shall relinquish possession of used motor oil except to:

1. A used oil collection center during hours of operation;
2. A county or municipally sponsored household hazardous waste collection event;
3. A hazardous waste transporter; or
4. A facility authorized by the state in which it is located to accept used motor oil.

(b) No person shall discharge water, antifreeze, industrial waste or any other contaminant into a used oil collection tank, or mix water, antifreeze, industrial waste or any other contaminant with used motor oil in any container which is then discharged into a used oil collection tank.

(c) Nothing in this subchapter shall require the owner or operator of a used oil collection center to accept used motor oil which the owner or operator reasonably suspects to contain water, antifreeze, industrial waste or any other contaminant.

7:26A-6.4 Labeling of motor oil containers

[(a)] Effective *[(the date 180 days after effective date to be inserted)]* ***July 6, 1993***, no person shall sell or offer for sale, at retail or at wholesale for direct retail sale in this State, any motor oil in containers unless the following statement is prominently displayed on the label:

[USED MOTOR OIL IS RECYCLABLE]
DON'T POLLUTE—CONSERVE RESOURCES;
RETURN USED OIL TO *[A]* COLLECTION CENTER***S***.

7:26A-6.5 Posting requirements

(a) Motor oil retailers shall conspicuously post and maintain a durable and legible metal sign, not less than 11 inches high by 15 inches wide, containing the following statement in characters no less than one inch in height:

DON'T POLLUTE—CONSERVE RESOURCES;
RETURN USED MOTOR OIL TO A COLLECTION
CENTER FOR RECYCLING

1. The sign shall be displayed in the following manner:

i. Suspended from the ceiling, or affixed to a wall, shelf, or free-standing display, at a height no greater than eight feet above the ground at its highest point and no less than four feet above the ground at its lowest point; and

ii. Adjacent to the motor oil display area or sales counter.

(b) The owner or operator of a used oil collection center shall, within 90 days of becoming subject to this subchapter, post and maintain a durable and legible metal sign, not less than 11 inches high by 15 inches wide, containing the following statement in characters no less than one inch in height:

USED OIL COLLECTION CENTER
RECYCLE YOUR USED MOTOR OIL HERE
TEN (10) QUART LIMIT PER PERSON
FEE: (If the used oil collection center charges
a fee for this service, the fee shall be
displayed as part of the sign.)

1. The sign shall be posted on an outside wall of the collection center, or other appropriate location, facing a public thoroughfare, to provide the public with an unobstructed view of the sign. This sign shall be displayed at a height no greater than eight feet above ground at its highest point and no less than four feet above the ground at its lowest point.

2. At his or her discretion, the owner or operator of a used oil collection center may accept more than 10 quarts of used motor oil per person per day, in which case he or she shall change the sign accordingly, to reflect the increased limit.

7:26A-6.6 Collection requirements and quantity limitations

(a)The owner or operator of any used oil collection center shall accept up to and including 10 quarts of used motor oil per day from the consumer. The owner or operator of the used oil collection center may, at his or her discretion, accept more than this amount. *[Once emptied,]*

(b) The owner or operator of a used oil collection center may return the container used to transport used motor oil***, once emptied,*** *[may be returned]* to the consumer at the discretion of the owner or operator or upon consumer demand. ***Alternatively, the owner or operator of the used oil collection center may dispose of the container as non-hazardous waste, in accordance with N.J.A.C. 7:26-8.4.***

7:26A-6.7 Management and transfer of used oil by used oil collection center

(a) The owner or operator of a used oil collection center shall manage and transfer used motor oil in compliance with the rules for hazardous waste management at N.J.A.C. 7:26. Once the used oil collection center accepts the used oil, it is designated as "waste oil" with hazrdous waste number X721. The used oil collection center is considered a "generator" of hazardous waste under N.J.A.C. 7:26-7. Hazardous waste management requirements include, but are not limited to, transferring collected waste oil only to a New Jersey licensed hazardous waste transporter for transport to a New Jersey hazardous waste facility licensed to accept waste oil, or for transport to a facility authorized to accept waste oil by the state in which the facility is located.

(b) An owner or operator of a used oil collection center may qualify for an exemption from the requirement to initiate a hazardous waste manifest for the waste oil if he ***or she*** meets the requirements of N.J.A.C. 7:26-7.7.

(c) A used oil collection center that accumulates more than 1,001 gallons of waste oil X721 at any one time is subject to the regulatory requirements applicable to hazardous waste facilities at N.J.A.C. 7:26-9.

*[7:26A-6.8 Reporting requirements

(a) The owner or operator of a used oil collection center shall semi-annually submit a report, by August 1 for the period of January 1 to June 30 and by February 1 for the period of July 1 to December 31, on forms designed by the Department, detailing used motor oil collection activity during the reporting period to the municipal recycling coordinator for the municipality in which the collection center is located.

(b) Each report shall include the following information:

1. The reporting period covered by the report;

2. Name, mailing address, and location (if different from the mailing address) of the used oil collection center;

3. Total quantity, in gallons, of used motor oil collected, including used motor oil collected as part of the collection center's business operations; and

4. For each New Jersey-licensed hazardous waste transporter utilized by the collection center, name, mailing address and quantity, in gallons, of used oil removed.

(c) Used oil collection centers will be required to manifest the waste oil, unless one of the exemptions in N.J.A.C. 7:26-7.7 is applicable.]*

7:26A-6.*[9]***8*** Notification requirements

(a) Each designated municipal recycling coordinator shall annually report the location, hours of operation and other pertinent information for any municipally sponsored used oil collection center located within that municipality. This information shall be submitted annually, on forms provided by the Department, by June 1 to the designated county recycling coordinator for the county in which the municipality is located.

(b) Each designated county recycling coordinator shall annually submit, on forms provided by the Department, by July 1 to the Department a list of municipally and county sponsored used oil collection centers located in that county.

7:26A-6.*[10]***9*** Penalties

The Department shall enforce the provisions of this subchapter in accordance with N.J.S.A. 13:1E-9, including the issuance of civil administrative penalties as provided at N.J.A.C. 7:26-5.5.

(a)

OFFICE OF ENERGY

Energy Conservation in State Buildings

Adopted New Rules: N.J.A.C. 7:32

Proposed: April 19, 1993 at 25 N.J.R. 1655(a).
Adopted: June 11, 1993 by Jeanne M. Fox, Deputy Commissioner, Department of Environmental Protection and Energy.
Filed: June 15, 1993 as R.1993 d.347, **without change.**

Authority: Reorganization Plan No. 002-1991, paragraph 2(a), as set out under N.J.S.A. 13:1D-1.
DEPE Docket Number: 27-93-03.

Effective Date: July 6, 1993.
Expiration Date: July 6, 1998.

Summary of Public Comments and Agency Responses:

On April 19, 1993, the Department of Environmental Protection and Energy (Department) proposed new rules at N.J.A.C. 7:32 to supersede N.J.A.C. 14A:13, which expired February 2, 1992. The Department held a public hearing on May 11, 1993, in Trenton, New Jersey. Joseph Sullivan served as hearing officer, and made no recommendations. The comment period for the proposed new rules closed May 19, 1993. **No comments were received.** The hearing record may be reviewed by contacting Janis Hoagland, Esq., Office of Legal Affairs, Department of Environmental Protection and Energy, CN 402, Trenton, NJ 08625.

Full text of the adoption follows.

CHAPTER 32
ENERGY CONSERVATION IN STATE BUILDINGS

SUBCHAPTER 1. ENERGY AUDITS AND ENERGY-CONSERVING RENOVATIONS OF STATE BUILDINGS

7:32-1.1 Scope and purpose

(a) This subchapter implements the Energy Conservation Bond Act of 1980, P.L.1980, c.68.

(b) The purpose of this subchapter is to provide for energy audits and energy-conserving renovations of State buildings in order to achieve a net reduction in the amount of energy consumed.

7:32-1.2 Definitions

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

"Act" means the Energy Conservation Bond Act of 1980. P.L.1980, c.68.

"Auditor" means an individual or company responsible for performing an energy audit, including, but not limited to, an architectural/engineering firm, independent professional engineer, or equipment vendor/manufacturer or facility management personnel.

"Autonomous agency" means any State department, division, or facility such as Rutgers The State University, the New Jersey Institute of Technology (NJIT), the New Jersey Department of Defense (NJDOD), the University of Medicine and Dentistry of New Jersey (UMDNJ), the State colleges upon approval of the Department of Higher Education (DHE), or any other agency which uses its own procurement and contract administration procedures.

"Commissioner" means the Commissioner of the Department of Environmental Protection and Energy.

"Commission" means the New Jersey Commission on Capital Budgeting and Planning.

"DBC" means the Division of Building and Construction in the Department of Treasury.

"DEPE" means the New Jersey Department of Environmental Protection and Energy.

"ECBP" means the Energy Conservation Bond Program.

"Energy audit" means a study of a building or facility administered by the Department of Environmental Protection and Energy, Office of Energy to determine operating and maintenance procedures and renovations which will result in reduced energy consumption.

"Energy Conservation Bond Fund" means the fund established pursuant to section 14 of the Energy Conservation Bond Act of 1980. P.L.1980, c.68.

"Energy-conserving operating and maintenance procedure" or "operating and maintenance procedure" means no-or low-cost renovations which can be implemented for the purpose of accomplishing a net reduction in the amount of energy consumed.

"Energy-conserving renovation" or "renovation" means the planning, improvement, reconstruction and rehabilitation of State buildings for the purpose of accomplishing a net reduction in the amount of energy consumed.

"Envelope" means the exterior surfaces of a building including the roof and walls, and penetrations of these surfaces, such as doors and windows.

"Payback" means the number of years required for the dollar savings to equal the total cost of implementation of the renovation.

"Project" means one energy conservation renovation or several energy conservation renovations which will be implemented together.

"State buildings" means buildings, structures and facilities under the supervision and control of any executive department of the State of New Jersey.

"Supervision and control" means the holding of any fee simple estate, or any leasehold estate for a duration of more than 10 years.

"Using agency" means any executive department of the State of New Jersey participating in the Energy Conservation Bond Program.

7:32-1.3 Submission of plan to the treasurer and the commission

(a) Beginning with fiscal year 1983, the Commissioner shall submit to the State Treasurer and the Commission for their review and recommendation with the DEPE's annual budget request a plan for expenditures of funds from the energy conservation bond fund for the upcoming fiscal year. This plan shall include the following information:

1. A performance evaluation of the expenditures made from the fund to date;
2. A description of programs planned during the upcoming fiscal year;
3. A copy of the regulations in force governing the operation of programs that are financed, in part or in whole, by the Energy Conservation Bond Fund;
4. An estimate of the amount of money and energy saved by the program to date; and
5. An estimate of expenditures for the upcoming fiscal year.

7:32-1.4 Submission of plan to the Legislature

Beginning with the fiscal year 1983, immediately following the submission to the Legislature of the Governor's annual budget message, the Commissioner shall submit to the relevant standing committee of the Legislature, as designated by the President of the Senate and the Speaker of the General Assembly, and to the special joint legislative committee created pursuant to Assembly Concurrent Resolution No. 66 of the 1968 Legislature, as reconstituted and continued by the Legislature from time to time, a copy of the plan called for under section 24 of the Act, together with such changes therein as may have been required by the Governor's budget message.

7:32-1.5 Consultation with special joint legislative committee

Not less than 30 days prior to entering into any contract, lease, obligation, or agreement to effectuate the purpose of the Act, the Commissioner shall report to and consult with the special joint legislative committee created pursuant to Assembly Concurrent Resolution No. 66 of the 1968 Legislature as reconstituted and continued from time to time by the Legislature.

7:32-1.6 Energy conservation renovation funding procedure

(a) Each using agency which has supervision and control over State buildings shall comply with the following procedures when requesting energy conservation funds:

1. The using agency shall submit to the ECBP its long-range plan for the facility, including data on planned additions, renovations and removals of buildings or facilities.

2. The using agency shall have an energy audit completed for the facility, building or special project that will be considered for energy conservation funding and shall submit the audit to the ECBP. The using agency can request the ECBP to fund the energy audit. All energy audits shall comply with N.J.A.C. 7:32-1.7, which sets forth the energy audit implementation procedures.

3. Upon completion and approval of the energy audit by the ECBP, the using agency may submit a request to the ECBP to fund the energy conservation renovations identified in the audit. Each request will be reviewed and ranked by the ECBP according to payback. The Department must comply with N.J.A.C. 7:32-1.9, which sets forth project funding request procedures.

4. The using agency will be notified by the Commissioner of the approved energy conservation renovations and their funding levels. Upon notification of approval, the using agency must implement the renovations, according to N.J.A.C. 7:32-1.10.

5. Upon project completion and acceptance by all parties, the ECBP shall review the final cost figures. The using agency will be subject to an audit and shall make available all records pertaining to the completed project. The using agency shall return any unused funds to the ECBP. Failure to comply with this requirement will result in the using agency's returning all ACBP funds awarded for additional projects and jeopardize future ECBP funding.

7:32-1.7 Energy audit implementation procedure

(a) Requests for funding to perform energy audits shall include:

1. The name of the facility;
2. The name/number and address of the buildings to be audited;
3. The gross square footage of each building;
4. The scope of the audit; and

5. An estimate of the cost of the audit.

(b) Requests for funding of energy audits shall be approved at the discretion of the ECBP and are subject to the following criteria:

1. That the audits requested do not duplicate existing audits or engineering studies considered acceptable by the ECBP;

2. That the estimated cost of an audit or analysis is not disproportionately great when compared to the possible savings that may be identified;

3. That the continued use of the building(s) or facility is consistent with the using agency's long-range plan; and

4. That energy audits are efficiently scheduled (that is, audits will be grouped by institution, location and technical similarities in order to keep the number of consultants to a minimum, reduce cost and expedite energy audits).

(c) Upon the Commissioner's approval of funding, the using agency shall submit to DBC a list of the energy audits to be performed. However, autonomous agencies shall use their own procurement procedures when energy audits will be performed at their facilities.

(d) All audits shall be in compliance with N.J.A.C. 7:32-1.8, which sets forth the required energy audit contents.

(e) The DBC or the autonomous agency shall coordinate with the ECBP to define the scope of the audit prior to advertising for the selection of the auditing firm.

(f) The DBC or autonomous agency shall select and retain an auditor.

(g) The using agency shall consult ECBP in the selection process of the auditor.

(h) The auditor shall submit the audit to the DBC and/or the using agency, and the ECBP. When the using agency is autonomous, the auditor shall submit the audit to the using agency and the ECBP. The ECBP and the using agency shall have 15 working days after receipt of the audit to notify the DBC of acceptance or of any deficiencies in the audit with regard to conformance with general auditing procedure, completion of specific tasks in the work assignment, and compliance with the audit content requirements of N.J.A.C. 7:32-1.8. If there are any deficiencies, the DBC or, when applicable, the autonomous agency, shall return the work product to the auditor marked "unacceptable."

(i) Upon acceptance of the completed audit, the ECBP shall transmit written approval of the audit to the using agency and the DBC. Final payment shall not be made until ECBP approval is on record.

7:32-1.8 Energy audit contents

(a) The energy audit shall include the following:

1. A description of building characteristics and energy data, including:

i. The operating characteristics of energy using systems; and

ii. A chart of energy use and cost data for each type of fuel used in the prior 12-month period;

2. A description and analysis of all potential energy-conserving maintenance and operating procedures, including:

i. A description of each maintenance and operating procedure;

ii. An estimate of the annual energy savings and energy cost savings expected from the implementation of each maintenance and operating procedure. In calculating the potential energy savings and energy cost savings, the auditor shall clearly show how energy savings and energy cost savings have been estimated by providing calculations for manual procedures, or by providing input data, methodology, equations, and sample calculations capable of verification for computer-generated results; and

iii. A cost estimate for implementing each maintenance and operating procedure.

3. A description and analysis of all potential energy conservation renovations, setting forth the following:

i. A description of each renovation;

ii. A cost estimate for the design and installation of each renovation;

iii. An estimate of the useful life of each renovation;

iv. An estimate of increases or decreases in maintenance and operating costs as a result of implementing each renovation, if any;

v. An estimate of the salvage value or disposal cost of each renovation at the end of its useful life;

vi. An estimate of the annual energy savings and energy cost savings expected from the implementation of each energy conservation renovation. In calculating the potential energy savings and energy cost savings the auditor shall:

(1) Assume that all energy savings obtained from energy conservation maintenance and operating procedures have been realized;

(2) Calculate the total energy savings and energy cost savings, by fuel type, expected to result from the implementation of all potential renovations, taking into account the interaction among the various renovations;

(3) Calculate the portion of the total energy savings and cost savings, as determined in (a)3ii above, attributable to each individual renovation; and

(4) Clearly show how energy savings and energy cost savings have been estimated by providing calculations for manual procedures, or by providing input data, methodology, equations, and sample calculations capable of verification for computer-generated results;

4. The payback of each potential energy-conserving renovation taking into account the interactions among the various renovations, and presented in the format established by the ECBP;

5. An analysis of the estimated energy consumption for each building or facility by fuel type in total British Thermal Units (BTU) and British Thermal Unit/Square Foot/Year (BTU/sq. ft./yr.) at optimum efficiency; and

6. A certification that the energy audit has been conducted in accordance with the requirements of this section, and that the auditors are free from conflicting financial interest in the products or equipment to be acquired and installed.

7:32-1.9 Energy conservation renovation funding request

(a) All requests to fund energy conservation renovations shall include the following:

1. An energy audit of the building/facility for which funding is requested;

2. Payback calculations for the implementation of the renovations, calculated by dividing the total implementation cost of the renovation(s) by the total dollar savings per year. Total dollar savings can include, but may not be limited to, direct energy savings, labor savings, equipment maintenance savings and avoided future capital costs;

3. Certification that the energy-conserving renovation is in conformance with the long-range plan for the facility and that the building or facility will not undergo major reconstruction, be vacated, condemned or demolished prior to the end of the payback period; and

4. A description and schedule of any non-energy construction or remodeling projects which must be coordinated with the energy-related projects for which funding is required.

(b) Requests for funding of energy-conserving renovations shall be evaluated for acceptability by ECBP according to the following criteria:

1. Compliance with (a) above a request may be returned to the submitting agency for revision if found to be incomplete or not in compliance;

2. Identification of proposed renovations which appear to require unusual or extensive maintenance. Supporting data may be required before acceptance; and

3. Proposed renovations which appear to require the State to use unproven or experimental systems shall not be accepted.

(c) Acceptable energy conservation renovations conforming to the requirements of (b) above shall be ranked according to payback.

(d) Based on the availability of funds, the ECBP shall establish the maximum acceptable payback for energy conservation renovations. However, the Commissioner, at his or her discretion, may include projects of higher payback, special need, merit or significance.

(e) Maximum payback established for any renovation shall not exceed 10 years.

(f) Upon selection and approval of energy conservation renovations for funding, the Commissioner shall notify the using agency, in writing, of such approval.

7:32-1.10 Energy conservation renovation implementation procedure

(a) The using agency must request, in writing, ECBP approval to start any project(s). This request shall include the following:

1. The name of the project; and
2. The estimated implementation cost.

(b) The using agency shall submit a scope of work for the project(s) to be implemented to the ECBP for approval. This shall include the intent of the proposed project as identified in the energy audit. Any revision of the scope of work shall be submitted to the ECBP for approval. Any revision done without written approval from the ECBP shall result in the using agency being held responsible for the funding of the project.

(c) Upon ECBP approval, funds will be transferred to the using agency according to the following conditions:

1. For projects with an estimated implementation cost of less than $50,000, the ECBP shall provide funds for design (design and preparation of plans and specifications) and construction (acquisition, installation and construction).

2. For projects with an estimated implementation cost of $50,000 or greater, the ECBP shall initially provide funds for the design only; this will be 10 percent of the estimated implementation cost. Funds for construction shall be provided based on the construction cost estimate submitted at the end of the design phase.

(d) The using agency shall issue contracts or submit progress reports showing equivalent progress in implementing the funded activities within three months of the date funds are transferred. Failure to do so shall result in the funds being returned to the energy conservation bond fund.

(e) The DBC shall select and retain an engineer or architectural/engineering firm for the design of energy-conserving renovations in accordance with the DBC's Architect/Engineer Selection Procedures. If the using agency is autonomous, it may use its own procurement procedures, provided that the architectural/engineering firm is prequalified by the DBC for projects of similar scope and that the ECBP gives formal approval. The ECBP must be consulted in the selection process of the architectural/engineering firm.

(f) The DBC or autonomous agency must notify the ECBP of the award of the project to the architect/engineering firm. This notification shall include the name of the firm, award date and amount of the design fee.

(g) The ECBP shall receive copies for review and approval of all submittals of design plans and specifications, including a final copy that is signed and sealed. As part of this review the ECBP shall confirm that the plans and specifications conform with the objectives of the original project scope of work, and verify that the costs to be incurred are, as far as practicable, solely for application to the purpose of the project. In the event that the submittals are deficient in these respects, the ECBP shall notify the using agency and the DBC or the autonomous agency in writing of same and that funds to complete implementation shall not be released for construction until the ECBP gives approval. In addition, the ECBP shall be notified of all design review meetings.

(h) The ECBP shall review and approve final cost figures for the project. Upon approval, the ECBP will transfer funds for the construction portion of the project to the using agency as provided in (c) above.

(i) Projects shall be advertised and put out for competitive bid by the DBC or, when applicable, by the autonomous agency, in accordance with the State bidding laws. All contractors bidding on the project shall be pre-qualified in accordance with applicable law and DBC regulation.

(j) In the event that the lowest responsible bid or sum of the bids exceeds the construction cost estimate by more than five percent, the bid(s) shall be subject to rejection by the DBC or autonomous agency. The DBC or the autonomous agency shall consider the effect of the bids on the estimated payback, and related factors.

1. The DBC and the using agency, or the autonomous agency, shall coordinate with the ECBP to determine if the project should be reduced in scope and re-bid to meet available funds and ECBP payback requirements or be canceled.

2. The DBC or the autonomous agency determines that the project shall be changed in scope, the ECBP shall determine whether the project still sufficiently conforms with the objectives of the original project to be funded.

(k) The DBC or autonomous agency must notify the ECBP of the award to the construction firm. This notification shall include the name of the firm, award date and the construction bid amount.

(l) The DBC or autonomous agency must notify the ECBP of all construction job meetings. Notification shall be given at least five working days in advance.

(m) The DBC or autonomous agency must notify the ECBP of the final inspection. Notification shall be given at least five working days in advance.

(n) Prior to project closeout, the using agency shall notify the ECBP in writing of its acceptance or rejection of the project. The ECBP shall notify the using agency of its final acceptance or rejection of the project. The project will not be considered complete until both parties have indicated final acceptance.

7:32-1.11 Project review and control

(a) The ECBP may require the installation of metering equipment as part of the project where such installation is economically and technically feasible in order that the ECBP may fulfill its statutory responsibility to annually report an estimate of the energy savings resulting from the implementation of the energy-conserving renovation.

(b) Each using agency will be required to submit a quarterly report to the ECBP during the duration and at the completion of the project. This report shall include financial and project status information for each ECBP funded project. Failure to provide reports will result in the cancellation of ECBP funded projects.

(c) Upon completion of the implementation of the energy-conserving renovations, the using agency shall annually provide the ECBP with actual energy savings realized from the implementation of the energy-conserving renovations.

(d) The using agency and/or the DBC shall be responsible for keeping the ECBP informed throughout all stages of the project. This shall include sending the ECBP copies of all relevant correspondence and financial information in a timely fashion.

(e) The DBC shall consider the ECBP as a co-using agency and as such shall place the ECBP on its distribution list for all documents that the ECBP needs to fulfill its statutory obligation of monitoring ECBP funded projects.

(f) The using agency shall be responsible for operating, maintaining, and servicing all equipment in accordance with the manufacturer's recommendations to obtain the maximum energy savings and as such shall be held financially liable.

(g) The using agency shall be responsible for pursuing all legal and administrative channels to ensure that the obligations of the architectural/engineering firms and contractors to the State are met. The using agency shall be held financially liable for failing to comply.

(h) The using agency shall be held financially liable if the anticipated savings from the energy conservation renovations are not fully realized as a result of negligence on the part of the using agency.

(i) The using agency shall be held responsible for any design fees paid to the architectural/engineering firm if the agency makes unauthorized changes which adversely affect the original architectural/engineering estimates and which may cause the project to be cancelled. This shall include escalations due to delays caused by the using agency.

(j) All change orders shall be subject to ECBP review and approval.

(k) The using agency shall return all unused funds to the energy conservation bond fund upon project closeout or at the request of the ECBP.

(l) The using agency must petition the ECBP in writing for any funds in addition to those originally authorized by the ECBP. Unau-

thorized expenditures shall result in all funds being returned to the energy conservation bond fund and will jeopardize future ECBP funding.

(m) The using agency shall be responsible for reporting its monthly energy consumption to the ECBP in the form prescribed by the ECBP. This shall include manual and computerized reporting procedures. The ECBP shall not consider funding requests from the using agency which do not comply with this requirement.

7:32-1.12 Eligible energy conservation renovations

(a) The following list outlines the types of energy conservation renovations which the ECBP has identified as resulting in a net reduction in the amount of energy consumed by a building or facility and which are eligible for energy conservation bond funds:

1. Energy conversion:
i. Boiler, furnace or water heater improvement or replacement;
ii. Chiller (refrigeration equipment) improvement or replacement; and
iii. Energy recovery installation.
2. Energy distribution:
i. Distribution system modification, improvement or replacement, including insulation of ducts and pipes;
ii. Heating, ventilation and air conditioning (HVAC) system modification, improvement or replacement;
iii. Metering installation; and
iv. Automatic control systems and automated energy management systems.
3. Electrical systems and lighting:
i. Light and/or fixture replacement;
ii. Motor improvement or replacement;
iii. Mechanical and electrical controls; and
iv. Automatic controls.
4. Envelope:
i. Double glazing or window replacement;
ii. Window treatment, including reflective or shading materials;
iii. Reduction of glass area;
iv. Roof insulation;
v. Wall insulation;
vi. Storm doors; and
vii. Storm windows.
5. Other: Specific renovations not listed which may be clearly shown to result in a net reduction of energy consumption or a reduction in the amount of dollars the State spends to purchase energy.

7:32-1.13 Designer qualifications

(a) In order to be qualified to design projects pursuant to this subchapter, the individual or firm must:

1. Be a New Jersey licensed professional engineer or architect, or a member of an architect-engineer team, the principal team members of which are licensed in New Jersey;
2. Be free from any financial interests which may conflict with the proper performance of his or her duties; and
3. Be pre-qualified by the DBC or autonomous agency.

HEALTH

(a)

EPIDEMIOLOGY, ENVIRONMENTAL AND OCCUPATIONAL HEALTH SERVICES

Sanitation in Retail Food Establishments and Food and Beverage Vending Machines

Temporary Retail Food Establishments and Agricultural Markets; Mobile Retail Food Establishments

Adopted Repeal: N.J.A.C. 8:24-8

Adopted New Rules: N.J.A.C. 8:24-8 and 9

Proposed: February 16, 1993 at 25 N.J.R. 662(a).
Adopted: June 14, 1993 by the Public Health Council, William Frascella, O.D., Chairman.
Filed: June 14, 1993 as R.1993 d.345, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:1A-7.

Effective Date: July 6, 1993.
Expiration Date: April 14, 1998.

Summary of Public Comments and Agency Responses:

The Department of Health, with the concurrence of the Public Health Council, is adopting a repeal and new rules at N.J.A.C. 8:24-8, governing temporary retail food establishments and agricultural markets, and new rules at N.J.A.C. 8:24-9, governing mobile food establishments. The comment period for the proposed repeal and new rules expired on March 18, 1993. The Department received several written comments from two local health departments concerning these amendments. Mr. Joseph Przywara, Environmental Health Coordinator of the Ocean County Health Department, and Suzanne Cavanaugh, Principal Sanitary Inspector of the Atlantic County Health Department. These were the only written or oral comments that the Department received concerning the amendments proposed on February 16, 1993.

The Department conducted a public hearing on the proposed readoption, with amendments, including these new rules, and on other proposals, on March 8, 1993. No one appeared for the purpose of commenting on the proposed readoption with amendments. James A. Blumenstock, hearing officer for the Department, recommended that the Department review, and respond appropriately to, any comments which may be received in writing. The hearing record may be reviewed by contacting Susan Eates, Department of Health, Health-Agriculture Bldg., CN 360, Trenton, NJ 08625.

COMMENT: Mr. Joseph Przywara, Ocean County Health Department, provided the following comment: N.J.A.C. 8:24-9.1(c) relates to mobile units or pushcarts which only serve prepared prepacked food items in individual servings. The last sentence states, "however, frankfurters may be prepared and served from these units or pushcarts" which, in his opinion, will create complications for the enforcing agency. He stated that "Rarely, if ever, are frankfurters sold by themselves. Usually they are accompanied by condiments including chili sauces, cheese sauces, etc." The commenter suggested that this section should be deleted or it should be made clear that other potentially hazardous foods cannot be prepared under these conditions.

RESPONSE: N.J.A.C. 8:24-9.1(c) addresses the requirements for mobile retail food establishments to provide on-board water supply, equipment washing and sanitizing facilities, and waste water storage tanks. The exemption from these requirements as provided in N.J.A.C. 8:24-9.1(c) for mobile food units or pushcarts which serve only frankfurters is taken directly from the U.S. Food and Drug Administration's Model Food Service Sanitation Manual. The Department believes that the referenced exemption for frankfurters also includes those foods such as condiments, sauerkraut, and commercially prepared chili that are traditionally served on frankfurters. Further, the Department believes that additional sanitary facilities such as a three compartment sink, water supply system, or wastewater holding tanks need not be required for serving of frankfurters or the heating and serving of limited quantities of toppings such as commercially prepared chili sauce, sauerkraut, or melted cheese; provided that the required equipment and utensil washing and sanitizing facilities are provided at the unit's base of operations/servicing area. Therefore, N.J.A.C. 8:24-9.1(c) will remain as proposed.

COMMENT: Mr. Joseph Przywara, Ocean County Health Department, provided the following comment: N.J.A.C. 8:24-9.3(a) allows for the unit to report daily or at a **lesser frequency** to its base of operations for all cleaning and servicing operations and for obtaining food supplies. This phrase will be interpreted by the vendors that it is at their discretion what the frequency of cleaning will be. This Department recognizes that N.J.A.C. 8:24-9.3(a) requires approval by the health authority but the actual enforcement of this can become difficult. It is suggested that this statement be deleted from the regulations and all mobile units should report daily to their commissary.

RESPONSE: The Department disagrees with the commenter and believes that it may not be necessary for every type of mobile retail food establishment to report at least daily to its designated base of operations.

N.J.A.C. 8:24-9.3(a) states that "The units shall report daily or at a lesser frequency **if deemed appropriate by the health authority** (underlined for emphasis) to such location for all cleaning and servicing operations and for obtaining those foods deemed necessary by the health authority." The Department believes that the frequency required for a mobile unit to report to its base of operations may be satisfactorily reduced based upon its menu, food and water storage capacity, available cleaning facilities, and waste water storage capacity and disposal needs. The Department believes that the local health authority which licenses and inspects the unit is in the best position to make this determination. This change also provides the local health authority with the discretion to modify the requirements of N.J.A.C. 8:24-9.3(a), when in its opinion no adverse effects regarding the safety of the foods served would be created and the sanitation requirements of this chapter can be satisfactorily achieved. Therefore, the N.J.A.C. 8:24-9.3(a) will remain the same as proposed.

COMMENT: Mr. Joseph Przywara, Ocean County Health Department, provided the following comment: N.J.A.C. 8:24-9.4(a) requires all servicing areas to be provided with overhead protection for supplying, cleaning, and servicing operations. Many of the current mobile units that are operating in Ocean County are converted recreational vehicles, bread trucks, or other units which are generally completely enclosed by the unit itself. This section was probably intended for the pushcarts or other open, exposed types of vending devices that required additional protection. It is suggested that a modification be made which would delete the requirement for overhead protection when the mobile food unit is an enclosed and protected facility. Also, the last sentence in this section does not require a servicing area if the foods placed on the mobile unit are packaged. The commenter is of the opinion that there appears to be a conflict with N.J.A.C. 8:24-9.1(c) in that only prepackaged food items need not meet the requirements relating to water and sewage, unless the word should have been "prepackaged" instead of "packaged."

RESPONSE: The Department agrees with the commenter. The mobile food unit's servicing area is required primarily for the replenishment of the water supply and for the disposal of waste water. Some mobile food units also use the servicing area for the storage and replenishment of food supplies and for the cleaning and sanitizing of food service equipment and utensils. The Department believes that overhead protection is necessary whenever the servicing area is used for the storage of food supplies and for the cleaning and sanitizing of equipment. However, it was not the Department's intent to require those servicing facilities used only for water replenishment and waste water disposal to be provided with overhead protection. In addition, the Department recognizes that many mobile food units are currently reporting to these servicing areas which are not provided with overhead protection. Therefore, the Department will amend N.J.A.C. 8:24-9.4(a) to reflect this consideration for these limited service facilities.

Regarding the commenter's suggestion that the word "packaged" should be changed to "prepackaged" foods, the Department agrees that the term prepackaged is more appropriate and will make this change to N.J.A.C. 8:24-9.4(a).

COMMENT: Mr. Joseph Przywara, Ocean County Health Department, provided the following comment: N.J.A.C. 8:24-9.4(b) requires the surface of the servicing area to be constructed of smooth, nonabsorbent material such as concrete, asphalt, etc. As mentioned previously, many units are completely enclosed and would not receive undue exposure if some of these surfaces were gravel or dirt. Again, it is suggested that a clarification of the surface requirement for these types of units be considered.

RESPONSE: The Department disagrees with the commenter. The Department believes that the surface of the servicing area must be constructed of a smooth nonabsorbent material which is graded to drain. Surfaces which do not meet these requirements are conducive to causing such conditions as mud, stagnant pooling water, and excessive amounts of dust which may contaminate water servicing connections. The Department does not agree that an enclosed vehicle would provide any additional significant protection from these contaminants which are compounded by driving over areas that are not smooth, nonabsorbent, or properly graded to drain. Further, the Department does not believe that compliance with this requirement would create an undue hardship for the unit operator because there is not a lack of servicing area facilities which are already properly paved to meet these requirements.

COMMENT: Ms. Suzanne Cavanaugh, Atlantic County Health Department, provided the following comment concerning N.J.A.C. 8:24-9.6(a) "Water supply." She stated that the amount of pressure and the hot water temperature considered sufficient for this operation needs to be specified.

RESPONSE: The Department does not agree with the commenter. N.J.A.C. 8:24-9.6(a) requires that a mobile food unit requiring a water system to have a potable water system under pressure with sufficient capacity to furnish hot and cold water for food preparation, utensil cleaning, and handwashing in accordance with the requirements of this chapter. It should be noted that the temperature requirements for water supply are not specified under the provisions of N.J.A.C. 8:24-6.1, Adequacy, safety and quality of water. Instead, the hot water temperature and water pressure requirements are specified under each provision for water use such as washing and sanitizing of equipment, and employee handwashing. Therefore, the requirements regarding the adequacy of the water pressure or temperature are adequately addressed in other more appropriate sections of the rules.

COMMENT: Ms. Suzanne Cavanaugh, Atlantic County Health Department, provided the following comment concerning N.J.A.C. 8:24-9.6(a) "Water supply." She stated that it is unclear from the utensil cleaning and sanitizing component of this section whether a three compartment sink is required on mobile units.

RESPONSE: N.J.A.C. 8:39-9.6(a) specifies the requirements for the water supply system to be provided to the mobile food unit. The rules do not specifically require all mobile food units to be provided with an on-board three compartment sink. The requirements for providing on-board equipment washing and sanitizing facilities such as a three compartment sink is based upon the nature of the unit and the proposed menu to be served. For instance, those mobile food units which have very limited on-board food preparation and which can satisfactorily wash and sanitize all necessary equipment at the base of operations/servicing area on a daily basis may not be required to provide a three compartment sink on-board the unit. The Department believes that the final determination as to what equipment is required rests with the health authority.

COMMENT: Ms. Suzanne Cavanaugh, Atlantic County Health Department, suggested that there should be a requirement to flush and periodically sanitize the water supply tanks provided on mobile food units.

RESPONSE: The Department agrees that there should be a requirement for the water supply tank on a mobile retail food establishment to be periodically sanitized. The Department has consulted with the U.S. Food and Drug Administration's Interstate Travel Service which requires that water holding tanks and tank trucks be periodically sanitized at a frequency determined by the company. However, because this change would require additional public notice and comment in accordance with N.J.A.C. 1:30-4.3, the Department will seek to amend N.J.A.C. 8:24-9.6(a) in the future proposal.

COMMENT: Ms. Suzanne Cavanaugh, from the Atlantic County Health Department, commented that the language relating to the discharge of liquid waste under N.J.A.C. 8:24-9.8, Liquid waste, is too vague. The rule should specify a septic system or city sewerage system as the only disposal alternatives.

RESPONSE: The provisions for the disposal of liquid waste are not only addressed under N.J.A.C. 8:39-9.8 but are also specified under N.J.A.C. 9.5(b) which states in part that "all liquid waste which is flushed from the liquid waste retention tank shall be discharged to a sanitary sewerage disposal system in accordance with N.J.A.C. 8:24-6.5." N.J.A.C. 8:24-6.5 requires all sewage to be disposed of by means of a public sewerage system; or a system in conformance with N.J.A.C. 7:9A, Standards for Individual Sub-surface Sewage Disposal Systems. Considering that most of the liquid waste generated from a mobile retail food establishment is that which is required to be collected in a liquid waste retention tank, the Department believes that the minimum requirements for liquid waste disposal as expressed by the commenter are already adequately addressed under N.J.A.C. 8:24-6.5 and 9.8. Therefore, it is not necessary to amend N.J.A.C. 8:24-9.8.

Full text of the adopted new rules follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

8:24-1.3 Definitions

For the purpose of this chapter, the following words, phrases, names and terms shall have the following meanings, unless the context clearly indicates otherwise:

...

"Temporary retail food establishment" means any retail food establishment which operates at a fixed location for a temporary period of time in connection with a fair, carnival, circus, public exhibition, or similar transitory gathering, including church suppers, picnics, or similar organizational meetings, as well as agricultural markets.

...

8:24-2.3 Shellfish source

(a) (No change.)

(b) Shellfish tagging and labeling shall be as follows:

1.-3. (No change.)

4. Immediately upon receipt of a container of shellstock or a lot of shucked stock, the purchaser shall mark the date of receipt on the stub or tag and when the package is empty, keep such stubs or tags on file for a period of not less than 90 days in an orderly fashion.

8:24-3.3 Food preparation

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

(g) Custards, cream fillings, and similar products which are prepared by hot or cold processes, and which are used as puddings or pastry fillings, shall be kept at safe temperatures at or above 140 degrees Fahrenheit or at or below 45 degrees Fahrenheit except during necessary periods of preparation and service, and shall meet the following requirements as applicable:

1. (No change.)

2. Such fillings and puddings shall be cooled to 45 degrees Fahrenheit or below as required by N.J.A.C. 8:24-3.2(c) immediately after cooking or preparation, and held there until combined into pastries, or served.

3. All completed custard filled and cream filled or similar type pastries shall, unless served immediately following filling, be cooled to 45 degrees Fahrenheit or below as required by N.J.A.C. 8:24-3.2(c) promptly after preparation, and held at that temperature until served. Synthetic filled products may be excluded from this requirement if:

i.-ii. (No change.)

iii. Other scientific evidence is on file with the health authority demonstrating that the specific product will not support the growth of pathogenic microorganisms.

4. (No change in text.)

8:24-3.4 Food storage

(a) Containers of food shall be stored a minimum of six inches above the floor in such a manner as to be protected from splash and other contamination except that:

1. (No change.)

2. The containers are stored on dollies, racks, pallets or skids that are easily movable.

(b)-(e) (No change.)

8:24-4.1 Health and disease controls

(a) Persons, while affected with any disease in a communicable form, or while a carrier of such disease, or while affected with boils, infected wounds, sores, acute respiratory infection, nausea, vomiting, or diarrhea which could cause food borne diseases such as staphylococcal intoxication, salmonellosis, shigellosis or hepatitis, shall not work in any area of a food establishment in any capacity in which there is a likelihood of such person contaminating food or food contact surfaces with pathogenic organisms, or transmitting disease to other individuals and no person known or suspected of being affected with any such disease or condition shall be employed in any such area or capacity.

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

8:24-4.2 Hygiene practices

(a) (No change.)

(b) Employees shall not use tobacco in any form while engaged in food preparation or service, nor while in equipment and utensil washing or food preparation areas, provided that locations in such areas may be designated by management for smoking, where no contamination of food, equipment, utensils, or other items needing protection will result.

(c) Employees shall consume food only in designated dining areas. An employee dining area shall not be so designated if consuming food there may result in contamination of other food, equipment, utensils or other items needing protection.

8:24-5.1 Design, construction and materials

(a)-(i) (No change.)

(j) Surfaces of equipment including shelves, not intended for contact with food, but which are exposed to splash, food debris, or otherwise require frequent cleaning, shall be reasonably smooth, washable, free of unnecessary ledges, projections, or crevices, readily accessible for cleaning, and of such materials and in such repair as to be readily maintained in a clean and sanitary condition. Fixed equipment designed and fabricated to be cleaned and sanitized by pressure spray methods shall have sealed electrical wiring, switches, and connections.

(k)-(n) (No change.)

8:24-5.4 Equipment and utensil sanitization

(a) (No change.)

(b) All kitchenware and food contact surfaces of equipment used in the preparation, service, display, or storage of potentially hazardous food shall be sanitized prior to such use, and following any interruption of operations during which contamination of the food contact surfaces is likely to have occurred. Where equipment and utensils are used for the preparation of potentially hazardous food on a continuous or production line basis, the food contact surfaces of such equipment, and utensils shall be cleaned and sanitized at intervals throughout the day on a schedule satisfactory to the Department or health authority.

8:24-5.5 Methods and facilities for washing and sanitizing

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

(d) Mechanical washing and sanitizing:

1. (No change.)

2. The flow pressure shall not be less than 15 or more than 25 pounds per square inch on the water line at the machine, and not less than 10 pounds per square inch at the rinse nozzles. A suitable gauge cock shall be provided immediately upstream from the final rinse valves to permit checking the flow pressure of the final rinse water on all machines.

3.-7. (No change.)

8. Any other type of machine, device, or facilities and procedures may be approved by the Department or local health authority for cleaning or sanitizing equipment and utensils, if it can be readily established that such machine, device, or facilities and procedures will routinely render equipment and utensils clean to sight and touch, and provide effective bactericidal treatment.

9. (No change.)

(e) (No change.)

8:24-5.6 Storage and handling of cleaned equipment and utensils

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

(c) The storage of food equipment, utensils or single service articles in toilet rooms, toilet vestibules or garbage or mechanical rooms is prohibited.

8:24-5.7 Single service articles

(a) Single service articles shall be made from clean, sanitary, nontoxic, safe materials. Equipment, utensils, and articles shall not impart odors, color, or taste, nor contribute to the contamination of food.

(b) Single service articles shall be stored at least six inches above the floor on pallets, dollies or racks, in closed cartons or containers which protect them from contamination and shall not be placed under exposed sewer lines or water lines that are leaking or on which condensate water may accumulate.

(c) When offered for self service, single service knives, forks and spoons packaged in bulk shall be inserted into holders or be wrapped by an employee who has washed his hands immediately prior to sorting or wrapping the utensils. Unless single service knives, forks and spoons are prewrapped or prepackaged, holders shall be provided to protect these items from contamination and present the handle of the utensil to the consumer.

(d) Single service articles shall be used only once.
(e) All retail food establishments which do not have adequate and effective facilities for cleaning and sanitizing utensils shall use single service articles.

8:24-6.1 Adequacy, safety and quality of water
(a) The water supply shall be adequate as to quantity, of a safe, sanitary quality, and from a public or private water supply system which is constructed, protected, operated, and maintained in conformance with the New Jersey Safe Drinking Water Act (N.J.S.A. 58:12A-1 et seq.) and regulations (N.J.A.C. 7:10) and local laws, ordinances, and regulations; provided, that if approved by the Department of Environmental Protection, a nonpotable water supply system may be permitted within the establishment for purposes such as air conditioning and fire protection, only if such system complies fully with N.J.A.C. 8:24-6.6 (Size, installation and maintenance of plumbing), and the nonpotable water supply is not used in such a manner as to bring it into contact, either directly or indirectly, with food, food equipment or utensils.
(b) (No change.)

8:24-6.5 Sewage
(a) All sewage shall be disposed of by means of:
1. (No change.)
2. A disposal system which is constructed and operated in conformance with N.J.A.C. 7:9A Standards for Individual Subsurface Sewage Disposal Systems, the New Jersey Water Pollution Control Act Regulations, N.J.A.C. 7:14, and local laws, ordinances, and regulations.

8:24-6.7 Drains
(a) (No change.)
(b) Each waste pipe from such equipment shall discharge into an open, accessible, individual waste sink, floor drain, or other suitable fixture which is properly trapped and vented; provided, that indirect connections of drain lines from other equipment used in the preparation of food or washing of equipment and utensils may be required by the Department or health authority when, in its opinion, the installation is such that backflow of sewage is likely to occur.
(c)-(d) (No change.)

8:24-6.10 Garbage and rubbish disposal facilities
(a) (No change.)
(b) All containers, while being stored, shall be provided with tight-fitting lids or covers and shall, unless kept in a special vermin proofed room or enclosure or in a waste refrigerator, be kept covered. Containers used in food preparation and utensil washing areas need not be covered; provided, that they are removed to the garbage storage area upon being filled or otherwise emptied at least daily.
(c)-(g) (No change.)
(h) Garbage or refuse storage rooms, if used, shall be constructed of easily cleanable, nonabsorbent, washable materials, shall be kept clean, shall be vermin-proof and shall be large enough to store the garbage and refuse containers that accumulate.
(i) (No change.)
(j) All garbage and rubbish shall be disposed of daily, or at such other frequencies and in such a manner as to prevent a public health nuisance, including the development of excessive odors and the attraction of vermin.
(k) (No change.)

8:24-7.1 Floor, walls and ceilings
(a) (No change.)
(b) The floor surfaces in kitchens, in all other rooms and areas in which food is stored or prepared and in which utensils are washed, and in walk-in refrigerators, dressing or locker rooms, and toilet rooms, shall be of smooth, nonabsorbent materials, and so constructed as to be easily cleanable; provided, that in areas subject to spilling or dripping of grease or fatty substances, such floor coverings shall be of grease resistant materials; and provided further, that floors of nonrefrigerated dry food storage areas need not be nonabsorbent.
(c)-(g) (No change.)
(h) Mats or duckboards, if utilized, shall be so constructed as to facilitate easy cleaning, and shall be kept clean. They shall be of such design and size as to permit easy daily removal for cleaning. Duckboards shall not be used as storage racks.
(i)-(n) (No change.)

8:24-7.2 Lighting
(a) (No change.)
(b) Permanently fixed artificial light sources shall be installed to provide, at a distance of 30 inches from the floor:
1. (No change.)
2. At least 10 foot candles of light in dry food storage areas, in walk-in refrigerators, and in all other areas. This shall also including dining areas during cleaning operations.

8:24-7.4 Housekeeping
(a)-(i) (No change.)
(j) The traffic of unnecessary persons through the food preparation and utensil washing areas is prohibited.
(k)-(l) (No change.)

SUBCHAPTER 8. TEMPORARY RETAIL FOOD ESTABLISHMENTS AND AGRICULTURAL MARKETS

8:24-8.1 General provisions
(a) All temporary retail food establishments and agricultural markets shall comply with all provisions of this chapter which are applicable to their operation; provided, that the Department or health authority may augment such requirements when needed to assure the service of safe food; may prohibit the sale of certain potentially hazardous food; and may modify specific requirements when, in its opinion, no imminent health hazard will result.
(b) Due to the nature, location and variety of conditions surrounding the operation of such establishments, it is frequently not possible to provide certain physical facilities required for "permanent" establishments. In order to assure adequate protection of food served by temporary establishments and agricultural markets which are unable to meet fully the requirements of this chapter, it may be necessary to restrict the types of food sold or the methods by which served, to modify some requirements for procedures and facilities, and to impose additional requirements.
(c) When, in the opinion of the Department or health authority, no imminent hazard to the public health will result, temporary retail food establishments and agricultural markets which do not fully meet the requirements of N.J.A.C. 8:24-2 through 7 may be permitted to operate when food preparation and service are restricted and deviations from full compliance are covered by the additional or modified requirements, as set forth in this subchapter.
(d) Any other requirement deemed necessary by the Department or health authority to protect the public health, in view of the particular nature of the food service operation, shall be met.

8:24-8.2 Restricted operations
(a) These provisions are applicable whenever a temporary food service establishment is permitted, under the provisions of N.J.A.C. 8:24-8.1(c), to operate without complying with all the requirements of this subchapter.
(b) The preparation of potentially hazardous food shall be prohibited, except that this prohibition shall not apply to:
1. Food which prior to service, requires only limited preparation, such as seasoning and cooking; or
2. Potentially hazardous food which is obtained in individual servings and is stored in approved facilities which maintain food at safe temperatures, below 45 degrees Fahrenheit or above 140 degrees Fahrenheit, and is served directly in the original individual container in which it was packaged at a food processing establishment.

8:24-8.3 Sources of ice
(a) Ice which will be consumed, or which will come into contact with food, shall be obtained in chipped, crushed or cubed form and shall be made from water meeting the requirements of N.J.A.C. 8:24-6.1(a).

(b) Ice which will come in contact with food shall be obtained, transported and stored in sanitary closed containers satisfactory to the Department or health authority.

8:24-8.4 Wet storage of food and beverages

(a) Wet storage of packaged food and beverages shall be prohibited; provided, that wet storage of pressurized containers of beverages may be permitted when:

1. The water contains at least 50 parts per million of available chlorine; and

2. The used water is changed frequently enough to keep both the water and container clean.

8:24-8.5 Food contact surfaces

(a) Food contact surfaces of food preparation equipment such as grills, stoves and worktables shall be protected from contamination by dust, customers, insects or any other source.

(b) Where necessary, effective shields shall be provided.

8:24-8.6 Equipment

Equipment shall be installed in such a manner that the establishment can be kept clean, and so that food will not become contaminated.

8:24-8.7 Single service articles

All temporary food service establishments without effective facilities for cleaning and sanitizing tableware shall provide only single service articles for use by the consumer.

8:24-8.8 Water supply

An adequate supply of water meeting the requirements of N.J.A.C. 8:24-6.1(a) for cleaning and handwashing shall be maintained in the establishment, and auxiliary heating facilities, capable of producing an ample supply of hot water for such purposes, shall be provided, except as provided in N.J.A.C. 8:24-8.9.

8:24-8.9 Handwashing facilities

(a) Adequate facilities shall be provided for employee handwashing.

(b) Such facilities may consist of commercially packaged handwash tissues, or a pan, water, soap and individual paper towels, when deemed appropriate by the health authority.

8:24-8.10 Liquid waste

All liquid waste shall be disposed of in such a manner as not to create a public health hazard or nuisance condition.

8:24-8.11 Floors

Floors shall be of tight wood, asphalt or other cleanable material; provided, that the Department or health authority may accept dirt or gravel floors when covered with removable, cleanable, platforms or duckboards, and graded to preclude the accumulation of liquids.

8:24-8.12 Walls and ceilings

(a) Walls and ceilings shall be so constructed as to minimize the entrance of flies and dust.

(b) Ceilings may be of wood, canvas or other materials which protect the interior of the establishment from the elements, and walls may be of such materials or of 16 mesh screening or equivalent.

(c) When flies are prevalent, counter service openings shall either be equipped with self-closing, fly-tight doors, or the opening shall be protected by effective fans. Where fans are used for this purpose, the size of the opening shall be so limited that the fans employed will effectively prevent the entrance of flies.

SUBCHAPTER 9. MOBILE RETAIL FOOD ESTABLISHMENTS

8:24-9.1 General provisions

(a) All mobile retail food establishments shall comply with all provisions of this chapter which are applicable to its operation; provided, that the Department or health authority may augment such requirements when needed to assure the service of safe food; may prohibit the sale of certain potentially hazardous food; and may modify specific requirements when in its opinion no imminent health hazard will result.

(b) When, in the opinion of the Department or health authority, no imminent hazard to the public health will result, mobile retail food establishments which do not fully meet the requirements of N.J.A.C. 8:24-2 through 7 may be permitted to operate when food preparation and service are restricted and deviations from full compliance are covered by the additional or modified requirements, as set forth in this subchapter.

(c) Mobile food units or pushcarts serving only food prepared, prepackaged in individual servings, transported and stored under conditions meeting the requirements of this chapter, or beverages that are not potentially hazardous and are dispensed from covered urns or other protected equipment, need not comply with requirements of this chapter pertaining to the necessity of water and sewage systems nor to those requirements pertaining to the cleaning and sanitization of equipment and utensils if the required equipment for cleaning and sanitization exists at the commissary. However, frankfurters may be prepared and served from these units or pushcarts.

(d) Any other requirement deemed necessary by the Department or health authority to protect the public health in view of the particular nature of the mobile food service operation shall be met.

8:24-9.2 Single service articles

Mobile food units or pushcarts shall provide only single service articles for use by the consumer.

8:24-9.3 Base of operations

(a) Mobile food units shall operate from a commissary or other fixed wholesale or retail food establishment. The units shall report daily or at a lesser frequency if deemed appropriate by the health authority to such location for all cleaning and servicing operations and for obtaining those food supplies deemed necessary by the health authority.

(b) The commissary or other fixed wholesale or retail food establishment used as a base of operation for mobile food units or pushcarts shall be constructed and operated in compliance with the requirements set forth under N.J.A.C. 8:24-1 through 7 for retail food establishment and N.J.A.C. 8:21 for wholesale food establishments.

8:24-9.4 Servicing area

(a) A mobile food unit servicing area shall be provided and shall include at least overhead protection for any supplying, cleaning, or servicing operation. ***Those servicing area facilities which are used only for the disposal of waste water and water supply replenishment are not required to have overhead protection.*** Within this servicing area, there shall be a location provided for the flushing and drainage of liquid wastes separate from the location provided for water servicing and for the loading and unloading of food and related supplies. The servicing area will not be required where only *[packaged]* ***prepackaged*** food is placed on the mobile food unit or pushcart or where all mobile food units do not contain waste retention tanks.

(b) The surface of the servicing area shall be constructed of a smooth nonabsorbent material, such as concrete or machine-laid asphalt, and shall be maintained in good repair, kept clean, and be graded to drain.

8:24-9.5 Servicing operations

(a) Potable water servicing equipment shall be installed in accordance with N.J.A.C. 8:24-6.6. Hose and hose connections for supplying potable water to the mobile units shall be provided. Such hose shall be equipped with a check valve or other device to eliminate possible contamination from return flow. There shall be facilities for hanging the hose for complete drainage and to avoid contamination.

(b) The mobile food unit liquid waste retention tank, where used, shall be thoroughly flushed and drained during the servicing operation. All liquid waste shall be discharged to a sanitary sewerage disposal system in accordance with N.J.A.C. 8:24-6.5

8:24-9.6 Water supply

(a) A mobile food unit requiring a water system shall have a potable water system under pressure. The system shall be of suffi-

cient capacity to furnish enough hot and cold water for food preparation, utensil cleaning and sanitizing, and handwashing, in accordance with the requirements of this chapter. The water inlet shall be located so that it will not be contaminated by waste discharge, road dust, oil, or grease, and it shall be kept capped unless being filled. The water inlet shall be provided with a transition connection of a size or type that will prevent its use for any other service. All water distribution pipes or tubing shall be constructed and installed in accordance with the requirements of this subchapter.

8:24-9.7 Handwashing facilities

(a) Handwashing facilities shall be provided for employee handwashing for mobile retail food service establishments where food products are directly handled and fabricated, but need not be provided for mobile units serving prepackaged foods, milk, cold sealed beverages and tea, coffee, hot chocolate or other hot drinks at temperatures above 140 degrees Fahrenheit.

(b) Facilities as in (a) above may consist of commercially packaged handwash tissues, or a pan, water, soap and individual paper towels, if deemed appropriate by the health authority.

8:24-9.8 Liquid waste

If liquid waste results from the operation of a mobile food unit, the waste shall be stored in a permanently installed retention tank that is at least 15 percent larger in capacity than the water supply tank. All connections on the vehicle for servicing mobile food unit waste disposal facilities shall be of a different size or type than those used for supplying potable water to the mobile food unit. The waste connection shall be located lower than the water inlet connection to preclude contamination of the potable water system. Liquid waste which is not discharged into a sewerage system shall be disposed of in such a manner as not to create a public health hazard or nuisance condition. Liquid waste shall not be discharged from the retention tank when the mobile food unit is in motion.

SUBCHAPTER 10. ENFORCEMENT PROVISIONS

Recodify existing N.J.A.C. 8:24-9.1 to 9.7 as 10.1 to 10.7 (No change in text.)

8:24-10.8 Public posting of inspection reports

(a) (No change in text.)

(b) An inspection report shall be presented by the inspector to the owner or person in charge or in their absence any employee of the establishments at the completion of each inspection. The evaluation placard shall be posted immediately in a conspicuous place near the public entrance of the establishment in such a manner that the public may view the placard.

(c) (No change.)

8:24-10.9 (No change in text.)

8:24-10.10 Report of inspections

Whenever an inspection of a retail food establishment is made, the findings shall be recorded on an inspection report form approved by the State Department of Health. The inspection report form shall identify in a narrative form the violations of this chapter and shall be cross referenced to the section of the chapter being violated.

8:24-10.11 Evaluation of reports

(a) Immediately upon the conclusion of the inspection, the licensed health officer or licensed sanitary inspector shall issue the evaluation of the establishment and leave the original copy with the person in charge. Evaluations shall be as follows:

1. (No change.)

2. Conditionally Satisfactory—At the time of the inspection, the establishment was found not to be operating in substantial compliance with this chapter and was in violation of one or more provisions of this chapter. Due to the nature of these violations, a reinspection shall be scheduled. The reinspection shall be conducted at an unannounced time. A full inspection shall be conducted. Opportunity for reinspection shall be offered within a reasonable time and shall be determined by the nature of the violation.

3. Unsatisfactory—Whenever a retail food establishment is operating in violation of this chapter, with one or more violations that constitute gross insanitary or unsafe conditions which pose an imminent health hazard, the health authority shall issue an unsatisfactory evaluation. The health authority shall immediately request the person in charge to voluntarily cease operation until it is shown on reinspection that conditions which warrant an unsatisfactory evaluation no longer exists. The health authority shall institute necessary measures provided by law to assure that the establishment does not prepare or serve food until the establishment is re-evaluated. These measures may include embargo, condemnation and injunctive relief.

8:24-10.12 (No change in text.)

SUBCHAPTER 11. REVIEW OF PLANS, MANAGER TRAINING AND CERTIFICATION

8:24-11.1 (No change in text.)

8:24-11.2 Pre-operational inspection

Whenever plans and specifications are required by N.J.A.C. 8:24-11.1 to be submitted to the regulatory authority, the regulatory authority shall inspect the retail food establishment prior to the start of operations, to determine compliance with the requirements of this chapter.

8:24-11.3 (No change in text.)

SUBCHAPTER 12. SANITARY REQUIREMENTS FOR THE VENDING OF FOOD AND BEVERAGES

Recodify existing N.J.A.C. 8:24-11.1 to 11.4 as 12.1 to 12.4 (No change in text.)

8:24-12.5 Interior construction and maintenance

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

(g) In machines designed so that food contact surfaces are not readily removable, all such surfaces intended for in-place cleaning shall be designed and fabricated so that:

1.-4. (No change.)

(h) The openings into all nonpressurized containers used for the storage of vendible food, including water, shall be provided with covers which prevent contamination from reaching the interior of the containers. Such covers shall be designed to provide a flange which overlaps the opening, and shall be sloped to provide drainage from the cover wherever the collection of condensation, moisture, or splash is possible. Concave covers are prohibited. Any port opening through the cover shall be flanged upward at least three-sixteenths inch, and shall be provided with an overlapping cover flanged downward. Condensation, drip, or dust deflecting aprons shall be provided on all piping, thermometers, equipment, rotary shafts, and other functional parts extending into the food container unless a water-tight joint is provided. Such aprons shall be considered as satisfactory covers for those openings which are in continuous use. Gaskets, if used, shall be of safe materials, durable and relatively nonabsorbent, and shall have a smooth surface. All gasket retaining grooves shall be easily cleanable.

(i)-(k) (No change.)

Recodify existing N.J.A.C. 8:24-11.6 and 11.7 as 12.6 and 12.7 (No change in text.)

8:24-12.8 Single service articles

Single service articles shall be purchased in sanitary packages which protect the articles from contamination, shall be stored in a clean, dry place until used, and shall be handled in a sanitary manner. Such articles shall be furnished to the customer in the original individual wrapper or from a sanitary single service dispenser. All single service articles shall be protected from manual contact, dust, insects, rodents and other contamination.

8:24-12.9 (No change in text.)

8:24-12.10 Water supply

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

(d) To prevent leaching of toxic materials caused by possible interaction of carbonated water, piping and contact surfaces, post-mix soft drink vending machines which are directly connected to the

external water supply system shall be equipped with a double (or two single) spring-loaded check valves or other devices which will provide positive protection against the entrance of carbon dioxide or carbonated water into the water supply system. Backflow preventive devices shall be located to facilitate servicing and maintenance. No copper tubing or other potentially toxic tubing or contact surfaces shall be permitted in or downstream from the check valves or backflow devices. These check valves or devices should be inspected and cleaned or replaced annually.

(e)-(f) (No change.)

Recodify existing N.J.A.C. 8:24-11.11 through 11.13 as 12.11 through 12.13 (No change in text.)

Recodify existing N.J.A.C. 8:24-12 and 13 as 13 and 14 (No change in text.)

(a)

DIVISION OF HEALTH FACILITIES EVALUATION

Licensing Standards for Long-Term Care Facilities

Readoption with Amendments: N.J.A.C. 8:39

Proposed: April 5, 1993 at 25 N.J.R. 1474(a).

Adopted: June 11, 1993 by Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).

Filed: June 14, 1993 as R.1993 d.341, **with a technical change** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

Effective Date: June 14, 1993, Readoption;
July 6, 1993, Amendments.

Expiration Date: June 14, 1998.

Summary of Public Comments and Agency Responses:

One letter of comment was received regarding the proposed new rule and amendments to the Licensing Standards for Long-Term Care Facilities, N.J.A.C. 8:39, from the New Jersey Association of Health Care Facilities (NJAHCF). There were no comments on the proposed readoption of the rules.

COMMENT: The proposed new rule at N.J.A.C. 8:39-2.10 addresses procedures to be followed by a long-term care facility requesting approval to increase its total licensed beds by no more than 10 beds or 10 percent of its licensed bed capacity. The rule specifies criteria which may be used by the Department to deny an application for add-a-beds. These criteria include violations of Federal certification requirements which might jeopardize the life, safety or quality of care of residents. According to proposed N.J.A.C. 8:39-2.10(c)1iii, issuance of one or more Federal Level A deficiencies in the same area on two or more consecutive visits may result in denial. NJAHCF suggests an addition of a new sentence to this section, as follows: "Except that such denial will be negated upon institution of a performance bond by said applicant assuring deficiencies in question will be expeditiously corrected and not reappear for a 12 month period of time." The Association commenter believes that such an addition would create a fairer system, especially for those owners who have more than one facility and have not had such deficiencies at their other facilities.

RESPONSE: The Department will review the suggested addition and will consider such language in the context of proposed comprehensive revisions to the licensing standards now under development. There remain a number of technical issues to resolve prior to amending the track record review criteria in this manner. As the Department would consider this a substantive change to the rule, a proposal incorporating this concept will be prepared for publication later in 1993.

COMMENT: The proposed amendment at N.J.A.C. 8:39-9.2, Mandatory policies and procedures for administration, reflects current statutes which require that residents who have advanced a security deposit to the facility prior to or on admission receive interest earnings on such funds and spells out requirements of the law. The rule, as proposed at 8:39-9.2(d), states that "effective July 1, 1993, all residents who have advanced a security deposit to a facility prior to or upon admission shall be entitled to receive interest earnings which accumulate on such funds or property after the effective date." The NJAHCF commenter requests deletion of the words "prior to or on admission," replacing them with the words "February 1, 1992 or thereafter." The Association believes that with this change the rule would be more consistent with the law as it is written.

RESPONSE: The Department's intent in proposing this rule is to afford all residents of nursing homes, irrespective of their date of admission, the right to interest earnings on personal funds left in trust with the facility as an admission security deposit. The Department interprets this action to be consistent with legislative intent and in accord with sound public policy, and therefore declines to make the suggested change.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 8:39.

Full text of the proposed new rule and amendment follows (addition to proposal indicated in boldface with asterisks ***thus***; deletion from proposal indicated in brackets with asterisks *[thus]*).

8:39-2.9 (Reserved)

8:39-2.10 Add-a-bed procedure

(a) Pursuant to N.J.S.A. 26:2H-7.2, a facility may request approval from the Department to increase total licensed beds by no more than 10 beds or 10 percent of its licensed bed capacity, whichever is less, without certificate of need approval.

(b) The application shall be filed, with an application fee of $250.00, using application forms provided by the Licensing, Certification and Standards program, and shall include: name, address, ownership, any other facilities owned, licensed capacity, any existing waivers, number of beds requested, proposed location of beds, any construction/renovation needed, a description of the project, number of single-bed rooms and square footage of dining/recreation area after increase, and additional staffing required.

(c) The Department may deny an application for add-a-beds based on the facility track record, using the following criteria:

1. Within the last 12 months preceding the date of application the applicant was cited for a violation of the licensing rules in this chapter or of Federal certification requirements for Medicaid or Medicare participation which presented a serious risk to the life, safety, or quality of care of the facility's patients or residents. A serious risk to life, safety, or quality of care of patients or residents includes, but is not limited to, deficiencies in State licensure or Federal certification requirements in the areas of nursing, patient rights, patient assessment of care plan, dietary services, infection control and sanitation, or pharmacy, resulting in:

i. An action by a State or Federal agency to curtail or temporarily suspend admissions to a facility; or

ii. Issuance of two or more Federal Level A deficiencies in the areas identified above; or

iii. Issuance of one or more Federal Level A deficiencies in the same area on two or more consecutive visits.

2. The applicant fails to demonstrate that the facility has sufficent space to implement the new licensed bed capacity in a manner meeting Federal construction standards contained in the Guidelines for Construction and Equipment of Hospital and Medical Facilities (1987 or current edition), as published by the American Institute of Architects and approved by the U.S. Department of Health and Human Services. (Available from the American Institute of Architects Press, 1735 New York Ave., NW, Washington, D.C. 20006); or

3. The applicant fails to demonstrate that the facility has provided minimum nurse staffing hours, in accordance with this chapter, sufficient to meet the needs of the current patient census.

8:39-9.2 Mandatory policies and procedures for administration

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

(d) Effective July *[1]***6***, 1993, all residents who have advanced a security deposit to a facility prior to or upon their admission shall be entitled to receive interest earnings which accumulate on such funds or property after the effective date.

1. The facility shall hold such funds or property in trust for the resident and they shall remain the property of the resident. All such

funds shall be held in an interest-bearing account as established under requirements of N.J.S.A. 30:13-1 et seq.

2. The facility may deduct an amount not to exceed one percent per annum of the amount so invested or deposited for costs of servicing and processing the accounts.

3. The facility within 60 days of establishing an account shall notify the resident, in writing, of the name of the bank or investment company holding the funds and the account number. The facility shall thereafter provide a quarterly statement to each resident it holds security funds in trust for identifying the balance, interest earned, and any deductions for charges or expenses incurred in accordance with the terms of the contract or agreement of admission.

Recodify existing (d) through (i) as (e) through (j) (No change in text.)

(a)

DIVISION OF HEALTH FACILITIES EVALUATION AND LICENSING

Drug Treatment Facilities
Standards for Licensure
Readoption: N.J.A.C. 8:42B

Proposed: April 5, 1993 at 25 N.J.R. 1476(a).
Adopted: June 11, 1993, by Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).
Filed: June 14, 1993 as R.1993 d.340, **without change.**

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

Effective Date: June 14, 1993.
Expiration Date: June 14, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 8:42B.

(b)

DRUG UTILIZATION REVIEW COUNCIL

Drug Evaluation and Acceptance Criteria
Readoption: N.J.A.C. 8:70

Proposed: May 3, 1993 at 25 N.J.R. 1814(a).
Adopted: June 8, 1993 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: June 14, 1993 as R.1993 d.333, **without change.**

Authority: N.J.S.A. 24:6E-6(g).

Effective Date: June 14, 1993.
Expiration Date: June 14, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 8:70.

(c)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products
Adopted Amendments: N.J.A.C. 8:71

Proposed: May 3, 1993 at 25 N.J.R. 1815(a).
Adopted: June 8, 1993 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: June 14, 1993 as R.1993 d.334, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: July 6, 1993.
Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:

The Drug Utilization Review Council received the following comments pertaining to the products affected by this adoption.

COMMENT: Lemmon Company informed the Council that it has not deleted Sulfanilamide vaginal cream 15% nor does it have any plans to withdraw the product's ANDA.

RESPONSE: The DURC agreed to retain this product in the Formulary.

COMMENT: Rugby Laboratories, Inc. informs the Council that chlorthiazide 250mg tabs, fenoprofen 600mg tabs, isoxsuprine 10mg and 20mg tabs, quinine sulfate 260mg tabs, manufactured by Chelsea Labs., are currently being produced and marketed.

RESPONSE: The DURC agreed to retain these products in the Formulary.

COMMENT: Pennex explains that it is in the process of acquiring lindane 1% lotion and shampoo from Pharmaceutical Basics (Bay) and requests that they not be deleted.

RESPONSE: The DURC agreed to retain these products in the Formulary.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the list of interchangeable drug products was held on May 24, 1993. Mark A. Strollo, R.Ph., M.S., served as hearing officer. Two persons attended the hearing. Three comments were offered, as summarized above. The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified as "not adopted," and referred the products identified as "pending" for further study. The hearing record may be reviewed by contacting Mark A. Strollo, R.Ph., M.S., Drug Utilization Review Council, New Jersey Department of Health, CN 360, Trenton, NJ 08625-0360.

The following products and their manufacturers were **adopted**:

Acetominophen 300/Codeine tabs 30mg	Boots Labs
Acetominophen with codeine phosphate tabs 300mg-15mg, 300mg-30mg	Barr
Acetominophen/codeine tabs 15mg, 30mg, 60mg	Duramed
Acetominophen/codeine tabs 60mg	Barr
Allopurinol tabs 100mg, 300mg	Barr
Amiloride tabs 5mg	Par
Aminophylline liquid 105mg/5ml	Bay
Amitriptyline/perphenazine tabs 2/10, 2/25	Danbury
Amitriptyline/perphenazine tabs 2/10, 2/25	Barr
Amitriptyline/perphenazine tabs 4/10, 4/25	Barr
Amitriptyline/perphenazine tabs 4/10, 4/25	Danbury
APAP/300mg Codeine tabs 30mg	Pharmafair
Bacitracin/Neomycin/Polymyxin ophth. oint.	Pharmafair
Belladonna alkaloids with phenobarbital tabs	Lemmon
Belladonna alkaloids with phenobarbital tabs	Richlyn
Belladonna alkaloids with phenobarbital tabs	Danbury
Berocca tabs substitute	Pioneer
Betamethasone dipropionate cr. & oint. 0.05%	Lemmon
Betamethasone valerate oint. 0.1%	Lemmon
Butabarbital Na tabs 15mg, 30mg	Lemmon
Butabarbital Sodium elixir 30mg/5ml	Bay
Chlordiazepoxide caps 10mg, 25mg	Pioneer
Chlordiazepoxide HCl caps 5mg, 10mg, 25mg	Lemmon
Chlordiazepoxide/amitriptyline 5/12.5, 10/25	Barr
Chlorpheneramine, phenylephrine, phenylpropanolamine, phenyltoloxamine syrup	Bay
Chlorpromazine HCl concentrate 30mg/ml, 100mg/ml	Bay
Chlorpropamide tabs 100mg, 250mg	Lemmon
Clindamycin caps 75mg	Biocraft
Clindamycin caps 75mg	Danbury
Clofibrate caps 500mg	Chelsea
Clonidine HCl tabs 0.1mg, 0.2mg, 0.3mg	Barr
Cyclandelate caps 200mg, 400mg	Chelsea
Cyclandelate caps 200mg, 400mg	Par
Cyclandelate caps 200mg, 400mg	Pioneer

Cyclandelate caps 200mg, 400mg	Sidmak
Cyproheptadine HCl tabs, 4mg	Danbury
Cyproheptadine HCl tabs, 4mg	Pioneer
Desipramine tabs 25mg, 50mg, 75mg, 100mg	PharmBasics
Dexamethasone ophth. soln. 0.1%	Americal
Dicyclomine HCl 10mg caps, 20mg tabs	Lemmon
Dicyclomine HCl caps 10mg, tabs 20mg	Richlyn
Dicyclomine HCl caps 10mg	Barr
Dicyclomine HCl caps 10mg	Danbury
Dicyclomine HCl caps 10mg	Pioneer
Dicyclomine HCl tabs 20mg	Barr
Dicyclomine tabs, 20mg	Pioneer
Diphenhydramine caps 25mg, 50mg	Pioneer
Diphenhydramine HCl caps 25mg, 50mg	Lemmon
Diphenhydramine HCl caps 25mg, 50mg	Richlyn
Diphenoxylate HCl with Atropine sulfate tablets 2.5mg with 0.025mg	Chelsea
Diphenoxylate HCl with Atropine sulfate tablets 2.5mg with 0.025mg	Barr
Diphenoxylate/Atropine tabs 2.5mg	Pharmafair
Diphenoxylate/Atropine tabs 2.5mg/0.025	Pharmafair
Dipyridamole tabs 25mg, 50mg, 75mg	Danbury
Disopyramide phosphate caps 100mg, 150mg	Barr
Doxepin HCl caps 10mg, 25mg, 50mg	Purepac
Doxepin HCl caps 75mg, 100mg, 150mg	Purepac
Doxycycline caps, 50mg	Lemmon
Doxycycline hyclate caps 50mg, 100mg	Barr
Doxycycline hyclate tabs 100mg	Barr
Erythromycin/Sulfisoxazole susp. 200/600	Barr
Fenoprofen caps 200mg, 300mg	Danbury
Flurazepam caps 15mg, 30mg	Barr
Furosemide tabs 20mg, 40mg	Chelsea
Gentamicin cream, ointment 1%	Pharmafair
Gentamicin ophth. soln. 3mg/ml	Americal
Gentamicin sulfate ophthalmic oint. 3mg/g	Pharmafair
Haloperidol tabs 0.5mg, 1mg, 2mg	Barr
Haloperidol tabs 5mg, 10mg, 20mg	Barr
HCTC tabs 25mg, 100mg	Danbury
Hydralazine HCl 10mg, 25mg, 50mg	Richlyn
Hydralazine HCl tabs 10mg, 25mg, 50mg, 100mg	Barr
Hydralazine HCl tabs 25mg, 50mg	Lemmon
Hydrochlorothiazide tabs 25mg, 50mg	Richlyn
Hydrochlorothiazide tabs 25mg, 50mg, 100mg	Barr
Hydrochlorothiazide tabs 50mg	Lemmon
Hydrocodone 5mg/Guaifenesin 200mg/ Pseudophedrine syrup, 60mg	Bay
Hydrocodone 5mg/phenylpropanolamine syrup 25mg	Bay
Hydrocodone 5mg/Pseudophedrine syrup, 60mg	Bay
Hydrocortisone/Neomycin/Polymyxin B otic susp.	Lemmon
Hydroxazine HCl tabs 10mg, 50mg, 100mg	Barr
Hydroxazine HCl tabs 10mg, 25mg, 50mg	Lemmon
Hydroxazine HCl tabs 10mg, 25mg, 50mg	Par
Hydroxyzine pamoate caps 50mg	Barr
Hydroxyzine pamoate capsules 50mg	Danbury
Ibuprofen tabs 300mg	Par
Ibuprofen tabs 400mg, 600mg	Danbury
Ibuprofen tabs 400mg, 600mg, 800mg	Barr
Ibuprofen tabs 800mg	Chelsea
Ibuprofen tabs 800mg	Purepac
Indomethacin caps 25mg, 50mg	Danbury
Indomethacin caps 25mg, 50mg	Lemmon
Indomethacin caps 25mg, 50mg	Par
Iodochlorhydroxyquin 3%/HC 0.5% cream 1%	Pharmafair
Isosorbide dinitrate tabs 5mg, 10mg, 20mg, 30mg	Barr
Isosorbide dinitrate tabs sl 2.5mg, 5mg	Barr
Lactulose syrup 10g/15ml	PharmBasics
Lorazepam tabs 0.5mg, 1mg, 2mg	Par
Lorazepam tabs 0.5mg, 1mg, 2mg	Barr
Meclizine HCl tab 12.5mg, 25mg	Richlyn
Meclizine HCl tabs 12.5mg, 25mg	Danbury
Meperidine tabs 50mg, 100mg	Barr
Metaproterenol Solution (inhalation) 5%	PharmBasics
Methocarbamol tabs 500mg, 750mg	Purepac
Methocarbamol tabs 500mg, 750mg	Pioneer
Methylclothiazide tabs 2.5mg, 5mg	Par
Methyldopa tabs 125mg, 250mg, 500mg	Barr
Metoclopramide tabs 10mg	Par
Metronidazole 250 tablets, 500mg	Chelsea
Metronidazole 250mg tablets, 500mg	Barr
Metronidazole tabs 250mg, 500mg	Par
Multiple vitamin with fluoride drops	Bay
Nacadixic acid tabs 250mg	Danbury
Naphazoline ophth. soln. 0.1%	Americal
Neomycin/Dexamethason ophth. soln.	Pharmafair
Nylidrin HCl tabs 6mg, 12mg	Danbury
Nylidrin HCl tabs 6mg, 12mg	Chelsea
Nylidrin HCl tabs 6mg, 12mg	Sidmak
Nylidrin HCl tabs 6mg, 12mg	USV
Nystatin vaginal tabs 100,000 units	Lemmon
Oxtriphylline elixir 100mg/5ml	Bay
Oxtriphylline elixir 50mg/5ml	Bay
Oxybutynin tablets, 5mg	PharmBasics
Oxycodone ASA tablets, 0.38/325mg	Barr
Oxycodone/APAP tabs 5/325	Barr
Oxytetracycline HCl caps 250mg	Richlyn
Papaverine HCl tabs 300mg	Sidmak
Perphenazine/amitriptyline 2/10, 2/25	Par
Perphenazine/amitriptyline 4/10, 4/25, 4/50	Par
Phenazopyridine HCl tabs 100mg, 200mg	Richlyn
Phenylbutazone caps 100mg	Barr
Polymyxin B Sulfate, Neomycin Sulfate, Hydrocortisone otic soln.	Pharmafair
Polymyxin B Sulfate, Neomycin Sulfate, Hydrocortisone otic susp.	Pharmafair
Prazepam caps 5mg, 10mg	PharmBasics
Prednisolone acetate sulfacet., 0.2%/10%	Pharmafair
Prednisolone sodium phosphate ophth. sol. 0.125%	Pharmafair
Prochlorperazine maleate tabs 5mg, 10mg, 25mg	Duramed
Propantheline bromide tabs 15mg	Richlyn
Propoxyphene HCl caps 65mg	Danbury
Propoxyphene HCl caps 65mg	Richlyn
Propoxyphene napsylate/APAP tabs 100/650	Barr
Propoxyphene napsylate/APAP tabs 50/325	Barr
Propranolol tabs 10mg, 20mg, 40mg	Par
Propranolol tabs 10mg, 20mg, 40mg	Barr
Propranolol tabs 60mg, 90mg	Danbury
Propranolol tabs 60mg, 80mg, 90mg	Par
Propranolol tabs 60mg, 80mg	Barr
Salsalate tabs 500mg, 750mg	Amide
Salsalate tabs 500mg, 750mg	Chelsea
Selenium sulfide lotion 2.5%	Bay
Sodium fluoride tabs 2.2mg	Pharmafair
Sodium fluoride chew tabs 2.2mg	Boots Labs
Spironolactone tabs 25mg	Barr
Sulfacetamide prednisolone ophth. soln.	Americal
Sulfacetamide sodium ophth. sol. 15%	Pharmafair
Sulfacetamide sodium/prepnisolone acetate ophth. oint.	Pharmafair
Sulfacetamide sodium/prepnisolone acetate ophth. susp.	Pharmafair
Sulfasalazine tabs 0.5g	Danbury
Sulfisoxizole tabs 500mg	Barr
Sulphacetamide ophth. sol. 15%	Americal
Tetracycline HCl caps 250mg, 500mg	Richlyn
Theophylline with Guaifensin liquid 150mg/15ml with 90mg/15ml	Bay
Theophylline with potassium iodide syrup	Bay
Thioridazine HCl oral solution, 30mg/ml, 100mg/ml	Bay
Thioridazine HCl tabs 10mg, 15mg, 25mg	Par
Thioridazine HCl tabs 50mg, 100mg	Par
Thioridizine HCl tabs 10mg, 15mg, 25mg, 50mg, 100mg	Barr
Thiothixene oral solution 5mg/ml	Lemmon
Tolazamide tabs 100mg, 250mg, 500mg	Par
Tolbutamide tabs 500mg	Barr
Traimcinolone acetonide cream 0.5%	Bay
Triamcinolone/nystatin cream	Pharmafair
Triamcinolone/nystatin oint.	Pharmafair
Trifluoperazine HCl tabs 1mg, 2mg, 5mg, 10mg	Duramed
Triple sulfa vaginal cream	Lemmon

Verapamil tabs 80mg, 120mg	Barr
Vitamin B Complex tabs	Pioneer
Vitamins A, D, C with fluoride solution 0.25mg	Bay

The following drugs were **not adopted as deletions but are still pending**:

Butalbital Aspirin/Caffeine tabs	Boots
Chlorthiazide tabs 250mg	Chelsea
Fenoprofen calcium tabs, 600mg	Chelsea
Isoxsuprine HCl tabs 10mg, 20mg	Chelsea
Lindane lotion and shampoo 1%	Bay
Meprobamate tabs 200mg, 400mg	Richlyn
Meprobamate tabs 200mg, 400mg	Barr
Meprobamate tabs 400mg	Purepac
Quinine sulfate tabs 260mg	Chelsea
Sulfanilamide vaginal cream 15%	Lemmon

(a)

DRUG UTILIZATION REVIEW COUNCIL
List of Interchangeable Drug Products
Adopted Amendments: N.J.A.C. 8:71

Proposed: May 3, 1993 at 25 N.J.R. 1814(b).
Adopted: June 8, 1993 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: June 14, 1993 as R.1993 d.335, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: July 6, 1993.
Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:
The Drug Utilization Review Council received **no comments** pertaining to the products affected by this adoption.

Summary of Hearing Officer's Recommendations and Agency Responses:
A public hearing on the proposed additions to the list of interchangeable drug products was held on May 24, 1993. Mark A. Strollo, R.Ph., M.S., served as hearing officer. Five persons attended the hearing. No comments were offered. The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified as "not adopted," and referred the products identified as "pending" for further study. The hearing record may be reviewed by contacting Mark A. Strollo, R.Ph., M.S., Drug Utilization Review Council, New Jersey Department of Health, CN 360, Trenton, NJ 08625-0360.

The following products and their manufacturers were **adopted**:

Albuterol tabs 2 mg, 4 mg	W-C
Atenolol tabs 50 mg, 100 mg	Mutual
Atenolol/chlorthalidone tabs 50/25, 100/25	Mutual
Berocca Plus tablet substitute	Westward
Clindamycin phosphate topical soln 1%	Greenstone
Clindamycin phosphate topical soln 1%	Lemmon
Diflunisal tabs 250 mg, 500 mg	Roxane
Fluphenazine HCl oral soln 5 mg/ml	Copley
Golytely substitute	Block
Piroxicam caps 10 mg, 20 mg	Mutual
Potassium Cl ER tabs 8 mEq	ALRA
Trazodone tabs 50 mg, 100 mg, 150 mg	Mutual

The following drugs were **not adopted but are still pending**:

Alprazolam tabs 0.25 mg, 1 mg, 2 mg	Lederle
Cyclobenzaprine tabs 10 mg	Duramed
Diltiazem tabs 30 mg, 60 mg, 90 mg, 120 mg	Mutual
Gemfibrozil tabs 600 mg	Lederle
Methocarbamol tabs 500 mg	Mutual
Minoxidil tabs 2.5 mg, 10 mg	Mutual
Naproxen sodium tabs 275 mg, 550 mg	Mutual
Naproxen sodium tabs 275 mg, 550 mg	Teva
Naproxen sodium tabs 275 mg, 550 mg	Purepac
Naproxen tabs 250 mg, 375 mg	Mutual
Naproxen tabs 250 mg, 375 mg, 500 mg	Teva
Naproxen tabs 250 mg, 375 mg, 500 mg	Lederle
Propoxyphene napsylate/APAP 50/325, 100/650	Mutual
Trazodone tabs 150 mg	Mutual
Tussi-organidin DM liq substitute	Mova

(b)

DRUG UTILIZATION REVIEW COUNCIL
List of Interchangeable Drug Products
Adopted Amendments: N.J.A.C. 8:71

Proposed: March 1, 1993 at 25 N.J.R. 875(a).
Adopted: June 8, 1993 by the Drug Utilization Review Council, Robert G. Kowalski, Chairman.
Filed: June 14, 1993 as R.1993 d.336, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: July 6, 1993.
Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:
No comments were received.

Summary of Hearing Officer's Recommendations and Agency Responses:
A public hearing on the proposed additions to the list of interchangeable drug products was held on March 29, 1993. Mark A. Strollo, R.Ph., M.S., served as hearing officer. One person attended the hearing. No comments were submitted. The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified as "not adopted," and referred the products identified as "pending" for further study. The hearing record may be reviewed by contacting Mark A. Strollo, R.Ph., M.S., Drug Utilization Review Council, New Jersey Department of Health, CN 360, Trenton, NJ 08625-0360.

The following products and their manufacturers were **adopted**:

Hydrocortisone acetate supp. 25mg	Bio-Pharm
Methotrexate tabs 2.5mg	Barr
Robitussin DAC syrup substitute	Halsey
Theophylline SR tabs 450mg	Sidmak
Trimethobenzamide HCl supp. 100mg, 200mg	Bio-Pharm

The following products were **not adopted but are still pending**:

Alprazolam tabs 0.25mg, 0.5mg, 1mg, 2mg	Greenstone
Benzoyl peroxide gel 5%, 10%	Glades/Stiefel
Carbidopa/levodopa tabs 10/100, 25/100, 25/250	Geneva
Diflunisal tabs 250mg, 500mg	Purepac
Guaifenesin SR tabs 600mg	Theraids
Guanabenz acetate tabs 4mg, 8mg	Zenith
Indomethacin supp. 50mg	G&W
Ketoprofen caps 50mg, 75mg	Geneva
Methazolamide tabs 25mg, 50mg	Geneva
Metoprolol tabs 50mg, 100mg	Geneva
Naproxen sodium tabs 275mg, 550mg	Geneva
Naproxen tabs 250mg, 375mg, 500mg	Geneva
Oxazepam caps 10mg, 15mg, 30mg	Geneva
Pindolol tabs 5mg, 10mg	Purepac
Piroxicam caps 10mg, 20mg	Zenith
Procainamide HCl SR tabs 500mg, 750mg	Copley
Triazolam tabs 0.125mg, 0.25mg	Greenstone
Tussi-Organidin DM liquid substitute	Bio-Pharm

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notice of adoption at 25 N.J.R. 1970(c).

(a)

DRUG UTILIZATION REVIEW COUNCIL
List of Interchangeable Drug Products
Adopted Amendments: N.J.A.C. 8:71

Proposed: January 4, 1993 at 25 N.J.R. 55(a).
Adopted: June 8, 1993 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: June 14, 1993 as R.1993 d.337, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: July 6, 1993.
Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:
No comments were received regarding the adopted products.

Summary of Hearing Officer's Recommendations and Agency Responses:
A public hearing on the proposed additions to the list of interchangeable drug products was held on February 1, 1993. Mark A. Strollo, R.Ph., M.S., served as hearing officer. Two persons attended the hearing. Two comments were offered, as summarized in a previous issue of the New Jersey Register (see 25 N.J.R. 1221(a)). The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," and referred the products identified as "pending" for further study. The hearing record may be reviewed by contacting Mark A. Strollo, R.Ph., M.S., Drug Utilization Review Council, New Jersey Department of Health, CN 360, Trenton, NJ 08625-0360.

The following products and their manufacturers were **adopted**:

Hydrocodone bitartrate/guaifenesin syrup	Barre-Nat'l
Hyoscyamine sulfate elixir 0.125mg/5ml	Hi-Tech
Hyoscyamine tabs 0.125mg	Trinity

The following products were **not adopted but are still pending**:

Aminophylline tabs 100mg, 200mg	West-ward
Atenolol/chlorthalidone 50/25, 100/25	Mylan
Cortisone acetate tabs 25mg	West-ward
Entex LA tabs substitute	Trinity
Histalet Forte substitute tabs	Trinity
Hydrocortisone tabs 20mg	West-ward
Ibuprofen tabs 400mg, 600mg, 800mg	Invamed
Metoclopramide oral solution 5mg/5ml	Silarex
Nadolol tabs 20mg, 40mg, 80mg, 120mg	Mylan
Naproxen tabs 250mg, 375mg, 500mg	Mylan
Naproxen tabs 250mg, 375mg, 500mg	Purepac
Nortriptyline caps 10, 25, 50, 75mg	Mylan
Oxtriphylline/guaifenesin elixir 100/50 per 5ml	Barre-Nat'l
Phenytoin suspension 125mg/5ml	Barre-Nat'l
Pindolol tabs 5mg, 10mg	Novopharm
Piroxicam caps 10mg, 20mg	Purepac
Prednisone tabs 5mg, 10mg, 20mg	West-ward
Rynatuss tabs substitute	Trinity
Singlet LA caps substitute	Trinity
Theo-Organidin elixir substitute	Barre-Nat'l
Triazolam tabs 0.125mg, 0.25mg	Mylan

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notice of adoption at 25 N.J.R. 1221(a) and 1969(c).

(b)

DRUG UTILIZATION REVIEW COUNCIL
List of Interchangeable Drug Products
Adopted Amendments: N.J.A.C. 8:71

Proposed: July 6, 1992 at 24 N.J.R. 2414(b).
Adopted: June 8, 1993 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: June 14, 1993 as R.1993 d.338, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: July 6, 1993.
Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:
There were **no comments** submitted pertaining to the proposed products affected by this adoption.

Summary of Hearing Officer's Recommendations and Agency Responses:
A public hearing on the proposed additions to the list of interchangeable drug products was held on August 3, 1992. Mark A. Strollo, R.Ph., M.S., served as hearing officer. Two persons attended the hearing. No comments were submitted. The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified as "not adopted," and referred the products identified as "pending" for further study. The hearing record may be reviewed by contacting Mark A. Strollo, R.Ph., M.S., Drug Utilization Review Council, New Jersey Department of Health, CN 360, Trenton, NJ 08625-0360.

The following products and their manufacturers were **adopted**:

Atenolol tabs 50mg, 100mg	Novopharm
Imipramine tabs 10mg, 25mg, 50mg	ALRA

The following products were **not adopted but are still pending**:

Acetazolamide tabs 250mg	ALRA
Atenolol tabs 25mg	Geneva
Clemastine fumarate tabs 1.34mg, 4.68mg	Geneva
Clonidine HCl/chlorthalidone tabs 0.1/15mg	Geneva
Clonidine HCl/chlorthalidone tabs 0.2/15mg	Geneva
Clonidine HCl/chlorthalidone tabs 0.3/15mg	Geneva
Clorazepate tabs 3.75mg, 7.5mg, 15mg	ALRA
Diltiazem tabs 30mg, 60mg, 90mg, 120 mg	Mutual
Fenoprofen caps 300mg	W-C
Fenoprofen tabs 600mg	W-C
Ibuprofen tabs 400mg, 600mg, 800mg	ALRA
Lactulose syrup 10g/15ml	ALRA
Loxapine caps 5mg, 10mg, 25mg, 50mg	Geneva
Metoclopramide tabs 5mg	Biocraft
Naproxen sodium tabs 275mg, 550mg	Mutual
Naproxen tabs 250mg, 375mg	Mutual
Nucofed expectorant substitute	LuChem
Pediazole suspension substitute	ALRA
Potassium bicarbonate effervescent tabs 25mEq	ALRA
Sucralfate tabs 1gm	Biocraft
Tolbutamide tabs 500mg	ALRA
Tolmetin sodium caps 400mg	Geneva
Tolmetin sodium caps 400mg	Lemmon
Triamterene/HCTZ tabs 37.5/25mg	Geneva

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notices of adoption at 24 N.J.R. 3174(a), 3728(a) and 4262(a), and 25 N.J.R. 583(a).

(a)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Adopted Amendments: N.J.A.C. 8:71

Proposed: November 2, 1992 at 24 N.J.R. 4009(a).
Adopted: June 8, 1993 by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: June 14, 1993 as R.1993 d.339, **with portions of the proposal not adopted but still pending.**
Authority: N.J.S.A. 24:6E-6(b).
Effective Date: July 6, 1993.
Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:
No comments were received regarding the adopted products.

Summary of Hearing Officer's Recommendations and Agency Responses:
A public hearing on the proposed additions to the list of interchangeable drug products was held on November 23, 1992. Mark A. Strollo, R.Ph., M.S., served as hearing officer. Seven persons attended the hearing. Six comments were offered, as summarized in a previous issue of the New Jersey Register (see 25 N.J.R. 580(b)). The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified as "not adopted," and referred the products identified as "pending" for further study. The hearing record may be reviewed by contacting Mark A. Strollo, R.Ph., M.S., Drug Utilization Review Council, New Jersey Department of Health, CN 360, Trenton, NJ 08625-0360.

The following products and their manufacturers were **adopted**:

Metoclopramide HCl tabs 10mg	Mutual
Temazepam caps 15mg, 30mg	Danbury

The following products were **not adopted but are still pending**:

Amoxapine tablets 25mg, 50mg, 100mg, 150mg	Danbury
Atenolol tablets 25mg	Danbury
Bromocriptine mesylate tabs 2.5mg	Danbury
Carbidopa/levodopa tabs 10/100, 25/100, 25/250	Purepac
Clorazepate dipotassium tablets 15 mg	Danbury
Clorazepate dipotassium tablets 3.75mg	Danbury
Clorazepate dipotassium tablets 7.5mg	Danbury
Desipramine HCl tabs 10mg, 25mg, 50mg	Danbury
Desipramine HCl tabs 75mg, 100mg, 150mg	Danbury
Entex PSE tablets substitute	Trinity
Fiorinal tablet substitute	Danbury
Fluphenazine HCl tabs 1mg, 2.5mg, 5mg, 10mg	Danbury
Gemfibrozil capsules 300mg	Danbury
Guaifenesin LA tablets 600mg	Trinity
Ibuprofen tablets 300mg	Danbury
Isosorbide dinitrate tablets 20mg, 30mg, 40mg	Danbury
Leucovorin calcium tablets 5mg, 25mg	Danbury
Levothyroxine sodium tabs 125mcg, 150mcg	Mova
Levothyroxine sodium tabs 200mcg, 300mcg	Mova
Levothyroxine sodium tabs 25mcg, 50mcg	Mova
Levothyroxine sodium tabs 75mcg, 100mcg	Mova
Loperamide capsules 2mg	Danbury
Loxapine succinate caps 5mg, 10mg, 25mg, 50mg	Danbury
Methylprednisolone tablets 4mg, 16mg	Danbury
Metoclopramide HCl tabs 5mg	Danbury
Metoprolol tabs 50mg, 100mg	Mutual
Minocycline HCl tablets 50mg, 100mg	Danbury
Nadolol tablets 40mg, 80mg, 120mg	Danbury
Pindolol tabs 5mg, 10mg	Lemmon
Pindolol tabs 5mg, 10mg	Mutual
Piroxicam caps 10mg, 20mg	Novopharm
Propantheline Br tablets 15mg	Danbury
Propoxyphlene napsylate/APAP tablets 100/650	Danbury
Spironolactone tablets 25mg, 50mg, 100mg	Danbury
Spironolactone/HCTZ tablets 50/50	Danbury
Timolol maleate tabs 5mg, 10mg, 20mg	Novopharm
Tolmetin sodium capsules 400mg	Danbury
Tolmetin sodium tablets 200mg	Danbury
Trazodone HCl tablets 150mg	Danbury

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notice of adoption at 25 N.J.R. 580(b).

HUMAN SERVICES

(b)

DIVISION OF YOUTH AND FAMILY SERVICES

Notice of Administrative Corrections

Manual of Requirements for Adoption Agencies

N.J.A.C. 10:121A-1.5, 3.4, 5.4, 5.5, 5.6, 5.8 and 5.10

Take notice that the Department of Human Services, Division of Youth and Family Services has discovered errors in the current text of N.J.A.C. 10:121A-1.5 in the definition of "Regular certificate of approval"; at N.J.A.C. 10:121A-3.4(c)1 in the Administration subchapter; and at N.J.A.C. 10:121A-5.4(g)1, (i)3 and (l)1ii; 5.5(b)2i; 5.6(f)11, (g)2ii and (j)1; 5.8(a)2i and (a)3i; and 5.10(e) in the Services subchapter. In the definition of "regular certificate of approval," the word "indicated" should read "indicates." At N.J.A.C. 10:121A-3.4(c)1, the telephone area code "(201)" should read "(908)." At N.J.A.C. 10:121A-5.4(g)1, 5.5(b)2i, 5.6, (f)11 and (j)1, and 5.8(a)2i and 3i, the final period should be a semicolon. At 10:121A-5.4(i)3 the phrase "their practice" should read "his or her practice." At 10:121A-5.4(l)1ii, the phrase "birth mothers" should read "birth mother." At N.J.A.C. 10:121A-5.6(f)11, the phrase "laboratory test" should read "laboratory tests." At N.J.A.C. 10:121A-5.6(g)2ii, the phrase "they are seeking" should read "he or she is seeking." At N.J.A.C. 10:121A-5.10(e), the phrase "my be included" should read "may be included." These errors are corrected through this notice of administrative correction, published pursuant to N.J.A.C. 1:30-2.7.

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

10:121A-1.5 Definitions
The following words and terms, when used in this chapter, shall have the indicated meanings:
...
"Regular certificate of approval" or "regular certificate" means a certificate in writing issued by the Bureau, which [indicated] **indicates** full compliance of an agency with the requirements of this chapter.
...

10:121A-3.4 Information to parents and adoption agencies
(a)-(b) (No change.)
(c) When a child has been identified by the agency as having a handicapping condition or suspected handicapping condition and services have not been arranged, the agency shall inform the parent(s) of their child's right to special educational and medical services and shall refer the parent(s) to:
1. The toll-free telephone number of the New Jersey Department of Education, Regional Curriculum Services Unit (currently 1-800-322-8174 in New Jersey and [(201)] **(908)** 390-6030 out-of-state) for a possible comprehensive evaluation and individual service plan for the child; and
2. (No change.)

10:121A-5.4 Services to birth parents
(a)-(f) (No change.)
(g) An agency that becomes involved in handling an identified adoption shall ensure that:
1. The birth parents have been offered counseling and alternatives to adoption, as specified in (c) and (d) above[.];
2.-5. (No change.)
(h) (No change.)

(i) An agency that provides services or payments for medical or hospital care shall ensure that the birth mother receives such medical or hospital care from:

1.-2. (No change.)

3. A private physician licensed to practice in the state where [their] **his or her** practice is located.

(j)-(k) (No change.)

(l) An agency that arranges for, provides directly, finances or subsidizes the costs of medical expenses, as specified in (i) through (k) above, of a birth mother shall comply with all of the following:

1. The agency shall maintain in a file a written policy that governs payments for medical or hospital care on behalf of birth mothers.

i. (No change.)

ii. The birth [mothers] **mother** shall be advised in writing, that any services or payments that she may be granted will be made to her without regard to her parents or future decision to surrender her child(ren) for adoption and that the agency will not require or request reimbursement from her for such services and/or payments.

2.-3. (No change.)

10:121A-5.5 Pre-placement services to the child

(a) (No change.)

(b) The agency shall provide foster care services, as necessary, to ensure the health and safety of children who are waiting for legal clearance and/or adoptive placement.

1. (No change.)

2. Before approving foster parents, the agency shall ensure that foster parents:

i. Submit written reports of medical examinations conducted within the past calendar year for all household members. These reports shall indicate that all household members are free of communicable diseases or other medical impediments to the placement of foster children in the home[.];

ii.-iv. (No change.)

3.-4. (No change.)

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

10:121A-5.6 Home study services

(a)-(e) (No change.)

(f) The agency shall obtain information on the applicants. Such information shall include but not be limited to:

1.-10. (No change.)

11. Written medical reports on each applicant and all other persons living in the home that include health, results of laboratory [test] **tests** or X-rays if ordered by the physician, and the physician's recommendation on the applicant's health status as it relates to the applicant's capacity to be an adoptive parent[.];

12.-18. (No change.)

(g) After the home study has been conducted, the social worker who conducted the study and the social work supervisor shall co-sign a letter to the adoptive parents or otherwise indicate in writing that the approval or rejection was made jointly.

1. (No change.)

2. The agency shall inform the applicant(s) of its decision in writing within 30 calendar days after the last contact with the applicant(s).

i. (No change.)

ii. When the applicant pursues a child(ren) different from the type(s) of child(ren) recommended by the agency, the agency shall re-evaluate the home study to determine if the applicant can be approved for the type of child [they are] **he or she is** seeking.

iii. (No change.)

(h)-(i) (No change.)

(j) For applicants who are being considered for adoption of one or more additional children, the agency shall:

1. Update the home study as specified in (i)1 and 2 above[.]; **and**

2. (No change.)

10:121A-5.8 Post-placement services

(a) For agency placements, the agency shall:

1. (No change.)

2. For children under five years of age, the agency shall:

i. Conduct bi-monthly home visits after the first visit for at least six months, except when the adoption is delayed past the six month supervisory period because the court has a backlog of cases. In these instances, the agency may conduct office visits on a quarterly basis instead of home visits until the adoption has been finalized[.];

ii.-iii. (No change.)

3. For children age five or older, the agency shall:

i. Conduct monthly home visits during the minimum supervisory six-month period, and then bi-monthly home or office visits until the adoption is finalized, if the court has a backlog of cases[.];

ii.-iii. (No change.)

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

10:121A-5.10 Searches

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

(e) The agency shall provide a handbook or pamphlet to each adult adoptee, birth parent and adoptive parent that outlines the range of services that [my] **may** be included in a search, the confidentiality rights/responsibilities of all parties that are involved in the search and the costs associated with the search.

CORRECTIONS

(a)

THE COMMISSIONER

Adult County Correctional Facilities Training and Staff Development

Adopted Amendments: N.J.A.C. 10A:31-5.1, 5.2 and 5.3

Proposed: May 3, 1993 at 25 N.J.R. 1817(a).

Adopted: June 7, 1993 by William H. Fauver, Commissioner, Department of Corrections.

Filed: June 9, 1993 as R.1993 d.324, **without change.**

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

Effective Date: July 6, 1993.

Expiration Date: March 5, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

10A:31-5.1 Training and Staff Development Program

(a) (No change.)

(b) The facility's Training and Staff Development Program, for all employees and all correction officers subject to the Police Training Act (N.J.S.A. 52:17B-66 et. seq.), shall be coordinated and supervised by a qualified training officer, at a supervisory level.

10A:31-5.2 Training officer

(a) The training officer shall have responsibility for planning and implementing:

1. The Police Training Commission (P.T.C.) training program; and

2. Civilian employee training programs.

(b) (No change.)

10A:31-5.3 Orientation and training for employees

(a) All new civilian employees shall receive orientation training prior to job assignment and additional training on an as needed basis.

(b) (No change.)

(c) All civilian employees who work in direct and continuing contact with inmates shall receive training that covers, at a minimum:

1.-13. (No change.)

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

(f) All personnel authorized to use firearms shall be trained in weaponry on a continuing, in-service basis as required by the Gun Control Act (N.J.S.A. 2C:39-6j).

(g) County correction officers shall complete Police Training Commission (P.T.C.) approved course at the Corrections Officers

Training Academy and Staff Development Center, New Jersey Department of Corrections or at an alternative P.T.C. approved school (see N.J.S.A. 52:17B-66 et seq.).

INSURANCE

(a)

DIVISION OF WORKERS' COMPENSATION RATING AND INSPECTION

New Jersey Workers' Compensation Managed Care Organizations

Adopted New Rules: N.J.A.C. 11:6-2

Proposed: April 5, 1993 at 25 N.J.R. 1330(a).
Adopted: June 14, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.
Filed: June 15, 1993 as R.1993 d.346, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1C-6(e); 34:15-15; and 34:15-88.

Effective Date: July 6, 1993.
Expiration Date: July 6, 1998.

Summary of Public Comments and Agency Responses:

A total of 38 commenters responded to the Department's proposed new rules. Eleven comments were received from the following insurance companies: New Jersey Manufacturers Insurance Company, Aetna Life and Casualty, CNA Insurance Companies, the Harleysville Insurance Companies, Selective Insurance, Crum & Forster Commercial Insurance, Kemper National Insurance Companies, The PMA Group, Fireman's Fund, Liberty Mutual Insurance Group and American International Companies.

Eight comments were received from the following managed care organizations, HMOs and PPOs: CONSERVCO, USHealthcare, FOCUS Healthcare Management, HIP Rutgers Health Plan, HealthCare COMPARE Corp., Consumer Health Network, Comprehensive Treatment Associates, P.A. and the Managed Care Alliance.

Thirteen comments were received from the following law firms and attorneys: Pellettieri, Rabstein and Altman; Jacobs, Schwalbe & Petruzelli, P.C.; Pirolli and Pirolli; Taylor Denker & Boguski; Cunningham & Byck; Montano, Summers, Mullen, Manuel, Owens & Gregorio; Tomar, Simonoff, Adourian & O'Brien; Schiffman & Aiello; Goldstein, Ballen, O'Rourke & Wildstein; Marcus & Levy; Lester S. Goldblatt, Esq.; Jon L. Gelman, Esq. and Leslie J. Jandoli, Esq.

Six comments were received from the following trade or professional associations and State departments: New Jersey State Bar Association, New Jersey Optometric Association, Alliance of American Insurers, American Insurance Association, Independent Insurance Agents of New Jersey and the New Jersey Department of Labor, Division of Workers' Compensation.

COMMENT: Several commenters expressed the opinion that the managed care system established by the rules is duplicative of the existing workers' compensation system in that employers are currently permitted to direct their injured employees to physicians of the employer's choosing, and the Compensation Rating and Inspection Bureau (CRIB) already may offer a premium reduction to insurers following a medical cost reduction program. Accordingly, these commenters believe that these rules are unnecessary and create an additional layer of bureaucracy that will increase administrative costs and fail to guarantee cost containment beyond what exists now.

RESPONSE: The Department agrees with these commenters insofar as under the current Workers' Compensation Law, employers may direct their injured employees to physicians of the employer's choosing, and CRIB's present rules may provide a premium reduction to insureds following a medical cost reduction program. However, it is the Department's position that these rules will encourage broader use of managed care and its attendant cost savings for treating injured workers. Therefore, as stated at proposed N.J.A.C. 11:6-2.1(a), the Department has proposed these rules to encourage employers to utilize managed care by offering a premium reduction as an incentive. These proposed rules prescribe standards applicable to all the various managed care programs. Accordingly, the Department believes these rules are necessary to ensure that a workers' compensation managed care system delivers quality medical care and cost savings.

COMMENT: One commenter which is not an insurer stated that the insurers in New Jersey are not supportive of the rules because the rules require insurers to reduce premiums and establish MCOs in order to compete for workers' compensation business. Several insurers, on the other hand, favor the workers' compensation managed care concept and wholeheartedly support the rules' capacity to create substantial savings in the workers' compensation area.

RESPONSE: The Department agrees with the insurers that use of a workers' compensation managed care system is expected to result in substantial cost savings.

COMMENT: One commenter stated that the rules should include language making the use of managed care mandatory where available.

RESPONSE: The Workers' Compensation Law (N.J.S.A. 34:15-1 et seq.) provides employers with the right to choose medical treatment and providers for injured employees. These rules are intended merely to provide incentives to employers to exercise this statutory right.

COMMENT: Several commenters stated that the MCOs' use of the HMO concept of high volume and less treatment, incompetent physicians or physicians without expertise in work-related injuries, and too much control given to insurers financing the MCOs will reduce the quality of medical care for injured workers and lead to higher costs.

RESPONSE: The Department disagrees with the commenter. All of the criteria under the proposed rules at N.J.A.C. 11:6-2.4 and 2.5 that must be met by MCOs in order to obtain Department approval for providing workers' compensation medical services will ensure that high-quality medical care will be provided to injured workers, while at the same time containing costs.

COMMENT: Some of the commenters stated that the rules' use of the HMO concept of providing medical care (that is, high volume, less treatment) is contrary to the requirement under the Worker's Compensation Law that an injured worker be provided with all reasonable and necessary medical care to restore injured workers to their prior functional level.

RESPONSE: The Department disagrees. The purpose of the workers' compensation managed care system is to provide appropriate, quality medical care so that injured employees can be back to work as soon as possible. This goal is consistent with the Workers' Compensation Law requirement that injured workers be provided with reasonable and necessary medical treatment so they may be restored to their prior functional level. Choosing to use a managed care system is an exercise of the employer's right under the Workers' Compensation Law to choose the medical treatment provided to injured employees. Moreover, the commenter fails to provide any basis for the assumption that an injured worker will not receive appropriate medical treatment as required by law under a managed care system.

COMMENT: Several commenters stated that they are generally pleased with the rules in that the managed care concept and MCOs as defined in the rules will increase the quality of care for injured employees and decrease costs and cost increases associated with the workers' compensation medical claim experience.

RESPONSE: The Department agrees.

COMMENT: One commenter recommended that, in addition to these rules, the Department consider meaningful tort reform and similar efforts to limit attorney involvement in areas other than workers' compensation.

RESPONSE: The Department believes that reduced litigation could lead to lower insurance costs in areas other than workers' compensation. However, this and similar areas of concern are beyond the scope of these rules.

COMMENT: Some of the commenters stated that since the rules embrace the HMO model of managed care, it will be difficult for non-HMOs to meet the MCO requirements contained in the rules. Thus, these non-HMOs will decline to participate, thereby decreasing competition and the savings sought by the Department.

RESPONSE: The criteria set forth in the rules are to ensure that quality medical care is provided to injured workers under a workers' compensation managed care system. All MCOs seeking to become a part of the Department's approved managed care system are required to meet Department standards. The Department does not believe that non-HMOs will be precluded from qualifying as approved MCOs.

COMMENT: One commenter stated that the rules are premature in that the work of the workers' compensation data collection and residual market committees set up by the Department is not yet complete.

RESPONSE: The purpose of these rules is to establish criteria required to be met by MCOs seeking to obtain Department approval for providing medical services under a workers' compensation policy in order for the insured under the policy to be eligible for a minimum five percent premium reduction. Although data collection and the residual market must also be addressed, the Department sees no purpose in delaying the MCO approval process by postponing the adoption of these rules.

COMMENT: A few commenters stated that the dispute resolution provisions in the rules at N.J.A.C. 11:6-2.4(a)7 and 2.5(b)11 are contrary to the Workers' Compensation Law (N.J.S.A. 34:15-1 et seq.). These commenters stated that they presume such dispute resolution is binding, thereby depriving injured workers of Workers Compensation Law procedures. The commenters further stated that the Department of Labor, Division of Workers' Compensation has sole jurisdiction under the Workers' Compensation Law to determine disputes involving injured workers. One commenter suggested that the rules place a reasonable time limit on any dispute resolution that may occur under the rules so as not to usurp the original jurisdiction of the Division of Workers' Compensation.

RESPONSE: The rule's dispute resolution provisions referred to by the commenters are part of the managed care system and are designed to avoid a disruption in the treatment of an injured worker. These dispute resolution processes are neither binding nor intended to replace dispute resolution procedures under the Workers' Compensation Law. Rather, these interim procedures may quickly resolve a dispute, and obviate the necessity for the matter to be prolonged or even reach the Division of Workers' Compensation.

COMMENT: One commenter suggested that the rules contain language to the effect that nothing in the rules infringes upon an injured worker's rights under the Workers Compensation Law and that the rules in no way diminish the original jurisdiction of the Division of Workers' Compensation.

RESPONSE: The Department agrees with the commenter's suggestion, and has added language to this effect at N.J.A.C. 11:6-2.1(b).

COMMENT: Several commenters stated that the rules will not accomplish any of their stated objectives and ultimately will be detrimental to injured workers. These commenters provided no basis for this opinion.

RESPONSE: The Department disagrees with these commenters and anticipates that a workers' compensation managed care system will accomplish the dual objectives of providing injured workers with appropriate medical care as required by the Workers' Compensation Law and containing medical costs.

COMMENT: Several commenters stated that the motive for the MCOs is profit, not additional benefits for injured workers.

RESPONSE: These rules are not intended to expand the scope of benefits which are provided to injured workers by statute, but to achieve the dual objectives of a workers' compensation managed care system, which are quality medical care and cost containment.

COMMENT: One commenter stated that by proposing these rules, the Commissioner of Insurance is attempting to create some type of health organization under the powers or aegis of the Administrative Code, and that this type of organization should be set up by the Commissioner of Health.

RESPONSE: The proposed rules do not create any type of health organization. Rather, the rules merely serve as a mechanism whereby existing managed care organizations may obtain the approval of the Department, in conjunction with the Department of Health, to provide medical services under a workers' compensation policy so that insureds under such a policy may be eligible for a premium reduction.

COMMENT: One commenter stated that public hearings should be conducted before the adoption of these rules because of their anticipated impact on the injured workers in the State.

RESPONSE: N.J.S.A. 52:14B-4(a)(3) requires an agency to conduct a public hearing on a proposed rule if such hearing has been requested by a committee of the Legislature or a governmental agency or subdivision, or if other statutory authority requires such a hearing. Additionally, an agency may elect to conduct a public hearing in order to elicit broad comment on pre-proposals or proposals which have potentially wide-ranging effect. The Department believes that the written comment period required by N.J.A.C. 1:30-3.3 provided sufficient opportunity for all interested parties to submit their comments to the Department for review and consideration.

COMMENT: A few commenters inquired whether all employers regardless of their premium level or classification type will be eligible to obtain the premium reduction. One commenter additionally suggested that if an employer opts to participate in the MCO program but fails to meet the standards of the plan, the employer should be subjected to a premium reduction decrease and a penalty.

RESPONSE: These comments address the details of the workers' compensation insurance rating system, which are set forth in the CRIB Manual. The Department acknowledges that the CRIB Manual will have to be amended, and that such amendments will resolve these issues. The comments are beyond the scope of these rules, which are limited to the Department's approval of MCOs.

COMMENT: One commenter inquired whether insurers will be required to offer the same premium reduction to all insured employers or whether the amount of the reduction will be based on the insured's claims experience.

RESPONSE: This comment also raises issues that must be addressed by amendment to the CRIB Manual and are beyond the scope of the present proposal.

COMMENT: A few commenters inquired whether the premium reduction will apply only to insureds agreeing to use the insurer's certified MCO after the insurer files a plan with CRIB and obtains CRIB's approval. A few commenters inquired whether an employer will be permitted to contract directly with an MCO having no affiliation with a workers' compensation carrier. A third commenter asked whether an insurer not intending to offer a premium reduction may provide medical services through an independently certified MCO.

RESPONSE: These comments address issues that must be resolved by amendment to the CRIB Manual, which sets forth the workers' compensation rating system, and are beyond the scope of this proposal.

COMMENT: One commenter agreed with the rules' requirement that insurers select the MCOs their insureds may use. The commenter stated that under the workers' compensation managed care system in place in Missouri, the employer selects the MCO, thereby placing on insurers the administrative burden of dealing with numerous MCOs.

RESPONSE: As was pointed out by the Department in the rules' Economic Impact Statement, the Department anticipates that an insurer's administrative costs will be maintained at a reasonable level by limiting the number of MCOs with which it is required to deal.

COMMENT: One commenter agreed with the rules' requirement that the MCOs provide both PPO and utilization management services. The commenter stated that under Missouri's workers' compensation managed care system, only PPO services are provided by the MCOs, and that medical cost management is more efficient when both are provided by the MCO.

RESPONSE: The Department agrees with the commenter, and has required that the MCOs seeking Department approval possess programs that provide both peer and utilization review to prevent inappropriate or excessive treatment.

COMMENT: One commenter inquired whether an insured may elect not to participate in the MCO program, but maintain the statutory right to control the medical treatment provided to injured workers.

RESPONSE: Yes. Participation in the managed care system is strictly voluntary, and an employer's rights under the Workers' Compensation Law are in no way infringed upon by these rules.

COMMENT: One commenter inquired whether insurers will be required to offer the MCO premium reduction to insureds in the residual market, whether the program will be identical to that offered in the voluntary market, and whether such premium reductions offered to the residual market will, in some instances, result in lower insurance costs than in the voluntary market.

RESPONSE: This comment raises an issue that is beyond the scope of these rules, and which must be addressed in amendments to the CRIB Manual.

COMMENT: One commenter inquired whether the MCO program and premium reduction would apply only to employers operating within the geographic areas served by the MCOs.

RESPONSE: Although this comment includes issues that must be resolved by amendment to the CRIB Manual, it also mentions the requirement in N.J.A.C. 11:6-2.4(a)2 that the MCO provide for medical care in certain geographic areas (that is, by county). The Department anticipates that MCOs serving a limited area may participate in this program, and that workers' compensation insurers may contract with

more than one approved MCO to cover a broader area. Insurers are encouraged to contract either with Statewide MCOs or a combination of MCOs that would cover all areas throughout the State.

COMMENT: A few commenters inquired whether the premium reduction will be calculated after applying experience modification factors. Another commenter suggested that the rules set forth the term of the premium reduction, and that the term should only be for two or three years because the cost savings would soon be reflected in experience modification factors. A third commenter inquired whether the premium reduction would be eliminated after improved experience is reflected in the employer's experience modification.

RESPONSE: These comments address issues that are to be resolved by amendments to the CRIB Manual.

COMMENT: One commenter expressed its opposition to the premium reduction, indicating that more efficient insurers may be penalized by being required to provide a reduction which exceeds actual savings and that a required minimum and/or maximum reduction will not account for differences in insurer books of business or geographic regions.

RESPONSE: Participation by workers' compensation insurers in the managed care program is strictly voluntary. An insurer which offers the MCO program will be required to offer at least a five percent savings to each employer in the program based on the expected cost savings.

COMMENT: One commenter stated that the rules place all accountability for managing care on the insurer, and that employers must be taking an active role in managing the care of their injured workers. The commenter suggested that employers receive a premium reduction only if they cooperate with and participate in the MCO.

RESPONSE: The Department agrees with the commenter that employers must take an active role in managing the care of their injured employees if the managed care method of delivering medical services to injured employees, thus cost savings to the insured employers, is to succeed. Employers seeking to participate in the managed care program proposed by these rules would be required to use the medical services of the certified MCO offered by the employer's insurer.

COMMENT: One commenter stated that the rules provide no basis for requiring a minimum five percent premium reduction nor any parameters governing the offer of a reduction exceeding five percent.

RESPONSE: The minimum five percent premium reduction is based on utilization and cost studies comparing managed care costs with standard medical care, which indicate that managed care has the potential to reduce expected medical claims costs by at least 10 percent. The premium reduction offered by insurers, which may exceed five percent, will depend on the estimated savings provided by the MCO.

COMMENT: One commenter inquired whether assessments will be calculated prior to application or net of the premium reduction.

RESPONSE: This comment raises an issue that must be addressed by amendments to the CRIB Manual, and is beyond the scope of this proposal.

COMMENT: A few commenters stated their opposition to mandatory managed care discounts applied to retrospectively-rated policies, indicating that actual losses used in calculating the retrospective premium should reflect the MCO savings.

RESPONSE: This issue must be resolved in amendments to the CRIB Manual.

COMMENT: One commenter inquired whether the insurer will be permitted to reduce or eliminate the insured's premium reduction if more than 20 percent of the insured's claim charges are from providers outside the MCO network.

RESPONSE: The specific duties of the employer, and the consequences for failure to use the MCO, will be set forth in the CRIB Manual forms and rules. The standard at N.J.A.C. 11:6-2.4(a)1 that, in the aggregate, services provided outside the network should not exceed 20 percent of the MCO's cost of medical and rehabilitative services is included only to provide a standard that the MCO must provide comprehensive services for injured workers.

COMMENT: One commenter inquired how the Department intended to measure the MCO's performance, and how it will be able to determine whether a reduction in losses is attributable to use of the MCO.

RESPONSE: The Department, through CRIB, is developing methods of assessing the performance of MCOs with regard to cost containment. An immediate measure of savings is not possible to ascertain, but as the experience develops it will be possible to compare MCO and non-MCO systems. Reporting of the premium reductions will provide a measure of the utilization of MCOs.

COMMENT: One commenter expressed its concern that the extremely restrictive MCO requirements contained in the rules will prevent carriers from qualifying as MCOs. This commenter also stated that it would be required to contract with a third-party provider in order for its presently-functioning MCO system to meet the rules' requirements. The commenter suggested that the rules be amended to permit a carrier's past performance to qualify it as an approved MCO in order to offer the premium reduction.

RESPONSE: The commenter, in effect, is suggesting that the Department develop a second set of standards whereby a carrier may qualify as an approved MCO. The Department plans to investigate this issue in the future; however, this area is beyond the scope of these rules as proposed.

COMMENT: One commenter inquired whether the rules are intended to govern an insurer's selection of an MCO or is intended to be the exclusive means of affording a premium reduction.

RESPONSE: The rules are intended to offer employers the opportunity to obtain a minimum five percent premium reduction on their workers' compensation policies by agreeing to utilize the services of an approved MCO. In order to become approved, an MCO must meet the standards set forth in these rules. An insurer seeking to offer the managed care premium reduction to its insureds must first contract with a state approved MCO and obtain CRIB approval. The rules are not *per se* intended to govern an insurer's choice of an MCO. The rules are intended to set forth those requirements and procedures necessary for an insurer to offer a premium reduction.

COMMENT: One commenter suggested that certain language contained in N.J.A.C. 11:6-2.1(a) be modified to track language contained in the Workers' Compensation Law. Specifically, the commenter suggests changing the rule language stating "[t]he purpose of this subchapter is to encourage the use of managed care to achieve quality care outcomes for the injured worker . . ." to "[t]he purpose of this subchapter is to encourage the use of managed care to furnish injured workers with such medical, surgical and other treatment, and hospital service, as shall be necessary to cure and relieve the worker of the effects of the injury . . ."

RESPONSE: The Department agrees that the commenter's suggested language change would clarify the rule's intent, and has made the suggested change.

COMMENT: Several commenters expressed their opposition to the care coordinator physician (CCP) concept in the MCO plan, as well as to the requirement at N.J.A.C. 11:6-2.5 that each MCO maintain a minimum of one CCP per 1,000 workers covered by the MCO. The commenters stated that the CCP concept is not easily transferable from the group health context to the workers' compensation arena. Unlike in group health, injured workers do not first consult with a CCP who then refers them to a specialist. Moreover, CCPs are not effective in ensuring quality of care because they have no experience in the area of workers' compensation, and are inefficient because they unnecessarily prolong the life of a case.

One commenter proposed that a centralized health services department headed by a registered professional nurse director, fully-versed in both workers' compensation and case management and under the direct guidance of the MCO's corporate medical department, handle the CCP functions.

One commenter requested a clarification of the definition of the term "care coordinator physician."

The commenters additionally stated that the rules' requirement of one CCP for every 1,000 covered workers is arbitrary, unrealistic and either overly-restrictive or overly-broad depending on the unique needs of the workers in various individual organizations. Moreover, it will be very difficult to monitor the ratio of CCPs to workers. Some of the commenters suggested either eliminating the CCP requirement or altering the ratio of one CCP per 1,000 workers.

RESPONSE: The Department believes that the commenters are confusing the workers' compensation managed care system's care coordinator physician with the group health primary care physician. The primary care physician, or gatekeeper, concept is usually a general practitioner or family physician with whom enrollees in the group health program are required to initially consult concerning any injury or illness. The primary care physician then refers the patient for any further specialized treatment or services. Unlike the primary care physician, the workers' compensation managed care system's care coordinator physician (CCP) is likely to be a specialist. A typical MCO would consist of any number of CCPs who are specialists in several different areas. At the time an injury or illness occurs, the worker would be referred by the

MCO to one of its CCPs depending on the type injury or illness involved. (For example, for an eye injury, the CCP may be an ophthalmologist.) The CCP would then be responsible for the treatment, care and any subsequent referrals, where appropriate, for that particular patient.

Other commenters are confusing the CCP with a case manager. The Department believes that it is obvious from the above explanation of the role of the CCP that the CCP cannot be a centralized health services department nor be eliminated as a requirement of a certified MCO.

The Department agrees with the comments concerning the rules' requirements of one CCP for every 1,000 covered workers. Accordingly, the Department has eliminated that requirement from N.J.A.C. 11:6-2.5(b)2, and replaced it with language indicating that the MCO shall maintain an adequate number of care coordinator physicians to provide the level and quality of medical treatment and services required under the Workers' Compensation Law.

COMMENT: A few commenters suggested that the definition of "case manager" be amended to include an employee of an insurer with a minimum of three years claims experience.

Another commenter stated that the case manager should be associated with the medical group with which the MCO contracts so as not to interfere with the medical group's ability to provide care, and suggested amending the definition to that effect.

Another commenter stated that only a licensed physician should qualify as a case manager, not a licensed registered nurse, in order to effectuate the Workers' Compensation Law and maintain the dignity and well-being of injured workers.

Other commenters stated that in most workers' compensation cases where medical treatment is simple and disability is short-term, a case manager is not necessary. Accordingly, the rule should contain criteria for the management of long-term disability type injuries, which should include coordination between a case manager and claims adjuster.

Another commenter suggested that the MCO's case management requirements at N.J.A.C. 11:6-2.4(a)4 be more clearly defined, especially "catastrophic case management."

Another commenter suggested that the language at N.J.A.C. 11:6-2.4(a)5 requiring that the MCO track and manage an injury from onset to resolution be changed to delete the management requirement.

RESPONSE: The Department strongly opposes the commenter's suggestion to amend the rules' definition of "case manager" to include an employee of an insurer with a minimum of three years claims experience. The MCO's case manager is not intended to be an insurance claims adjuster. Rather, the case manager must be a licensed health care professional responsible for coordinating an injured worker's care, including ensuring that the worker has access to the full range of services required to cure and relieve the worker of the effects of the injury.

The Department additionally opposes amending the "case manager" definition to permit the case manager to be associated with the medical group with which the MCO contracts. One of the basic concepts of managed care is that the MCO be responsible for case management. Accordingly, the rules require the case manager to be an employee of the MCO.

The Department further disagrees with the suggestion that only a licensed physician should qualify as a case manager, not a licensed registered nurse. The Department believes that a licensed registered nurse is qualified to perform the functions of the MCO case manager.

The Department agrees with the comment that case management may not be necessary in all cases. The rules do not require that an MCO provide a case manager for each and every case. Rather, the rules require only that an MCO provide a case management program. That program should establish the MCO's case management protocol.

The Department does not believe that further clarification is necessary concerning the requirement at N.J.A.C. 11:6-2.4(a)4 that the MCO provide case management. As previously stated, the MCO is required to establish a case management program that includes medical catastrophic and disability case management. Typically, use of the term "catastrophic case management" refers to the management of high-cost and/or complex cases.

The Department opposes the suggestion to eliminate the MCO case management requirement. The Department reiterates that the MCO itself will be responsible for determining the extent of management necessary in each individual case. The rules require only that the MCO establish a case management program.

COMMENT: One commenter stated that the rules' definition of "health care provider" is too broad. The commenter suggested redefining a health care provider as an entity or group of entities comprised of licensed physicians and other medical support personnel who are competent to provide medical services, medical treatment, physicians' services and physicians' treatment as defined by N.J.S.A. 34:15-1 et seq. and interpreting case law.

RESPONSE: Upon re-reviewing the rules' proposed definitions, the Department has determined that it is appropriate to delete the definition of both "health care provider" and "health care services." These terms appear in the rules only minimally at N.J.A.C. 11:6-2.5(b)4 and 2.7(a)3 and 5, and can be replaced with the terms "medical service provider" or "medical services" without affecting the meaning of those provisions.

COMMENT: A few commenters stated their concern with the rules' definition of "health care services." One commenter stated that dental services should be included. Another commenter stated that "optometrical" services should be changed to either optometry or optometric. A third commenter suggested redefining the term to mean those services provided for by N.J.S.A. 34:15-1 et seq. and interpreting case law. Another commenter suggested deleting the definition since the term does not appear in the rules.

RESPONSE: Upon re-reviewing the rules' proposed definitions, the Department has determined that it is appropriate to delete the definition of both "health care provider" and "health care services." These terms appear in the rule only minimally at N.J.A.C. 11:6-2.5(b)4 and 2.7(a)3 and 5, and can be replaced with the terms "medical service provider" or "medical services" without affecting the meaning of those provisions.

COMMENT: A few commenters suggested changing the definition of "managed care organization." One commenter suggested the definition be broadened to include PPOs and HMOs. Another commenter suggested an MCO be defined as a composition of competent licensed physicians and support staff capable of providing medical care in accordance with N.J.S.A. 34:15-1 et seq.

RESPONSE: The Department believes that the rules' current definition of "managed care organization" is sufficiently broad to encompass all of these commenters' suggestions.

COMMENT: Several commenters voiced their concern with the rules' definition of "medical director." Some commenters stated that the definition should be expanded. One commenter stated the definition should include family practice and emergency room physicians since these individuals make excellent medical directors because of their breadth of clinical experience and ability to coordinate and facilitate care and communication across many specialties.

Another commenter stated that the definition should include physiatrists, a new specialty specifically developed for handling workers' compensation cases; a physiatrist is a physician provider with training in both rehabilitation and internal medicine.

Another commenter believes the definition should be expanded to include the medical director of a PPO with which the MCO may contract for services. Yet another commenter suggested amending the definition to include an individual employed by or under contract with, directly or indirectly, an MCO.

Some commenters stated that it is both unrealistic and unnecessary to require a medical director to be a full-time employee of the MCO. The commenters stated that this is a costly position, and that an MCO can sub-contract to fill the role or employ the director part-time.

Some commenters stated that it is unnecessary for a medical director to be a board certified physician since that qualification has little connection with the management functions of the position. This requirement reduces the pool of qualified managers, which could impede the formation of MCOs.

Other commenters disagreed with the functions of the medical director as set forth in the rules' definition. One commenter stated that the definition places much more responsibility on the medical director than the typical overall management and supervision of the MCO. Two commenters stated the medical director's functions as set forth in the definition are redundant of those of the CCP (that is, day-to-day direction). Rather, the medical director should be responsible for developing standard treatment protocols, utilization review criteria and quality assurance standards.

RESPONSE: The Department believes it is unnecessary to expand the rules' current definition of "medical director" to include family practice or emergency room physicians of physiatrists. The language "or related fields" contained in the definition serves to include such physicians.

The Department opposes the suggestion to expand the definition to include either the medical director of a PPO with which the MCO may contract for services or an individual employed by or under contract with,

directly or indirectly, an MCO. The Department intentionally required that an MCO enter a direct employment or contractual relationship with its medical director, and not place the responsibility elsewhere, so as to ensure the success of the managed care concept.

The Department's definition of "medical director" does not require the individual filling that position to be employed on a full-time basis with the MCO. Rather the definition requires the medical director to be available to the MCO to provide full-time management and supervision of medical care. This requirement does not necessarily require the individual's physical presence at the MCO on a full-time basis to the exclusion of other employment.

The Department believes that the rules' requirement that the medical director be a board certified physician is necessary in order for the medical director to properly effectuate the functions of that position, including competently supervising the medical care being provided by the MCO's medical providers. This requirement does not reduce the pool of qualified medical directors since the number of fields in which a medical director may be board certified is broad enough so that the formation of MCOs will not be impeded.

The Department disagrees with the comment that the rules' definition places more responsibility on the medical director than the typical overall management and supervision of the MCO. The definition requires that the medical director provide "day-to-day direction, management and supervision of medical care." Further, the medical director's functions are not redundant of those of the care coordinator physician (CCP), who is responsible for providing direct medical care to injured workers.

COMMENT: One commenter suggested that the definitions of "medical service" and "medical service provider" include optometric services.

RESPONSE: The Department believes that the rules' current definition of "medical services," which includes the language "or related services," is sufficiently broad to include optometric services. The rules' definition of "medical service provider" likewise would include optometrists so long as they are licensed to furnish such services.

COMMENT: One commenter suggested that the definition of "physician" include optometrists consistent with the definition in the Federal Medicare program where optometrists are defined as physicians within their state licensure limits.

RESPONSE: The Department believes that the rules' current definition of "physician" is sufficiently broad to include Optometrists.

COMMENT: One commenter requested that the term "rehabilitative services" appearing at N.J.A.C. 11:6-2.4(a)1 be defined more specifically since it is unclear what type of rehabilitation the term includes (vocational rehabilitation, physical rehabilitation, etc.)

RESPONSE: The rules' reference to the term "rehabilitative services" is intended to include all such services required to be provided in accordance with the Workers' Compensation Law.

COMMENT: Several commenters requested clarification of the roles of the employer, the MCO and the insurer concerning the rules' requirement at N.J.A.C. 11:6-2.4(a)10 that the MCO have a fraud detection plan to be coordinated with the insurer's fraud prevention plan. A few commenters questioned whether insurers are expected to purchase the MCO's fraud detection services; others believed the MCO should be responsible only for alerting the insurer of suspected fraud.

RESPONSE: All parties involved in the managed care system—insurers, MCOs, providers, employers, employees—are responsible to some degree for reporting suspected fraud. The rules merely require that an MCO have a fraud detection plan that includes measures for the initial detection and reporting of suspected fraud. Insurers are not required under these rules to purchase the fraud detection services of an MCO.

COMMENT: Several commenters commented on the rules' provision at N.J.A.C. 11:6-2.4(a)1 stating that services provided outside the MCO network should not exceed 20 percent of the MCO's cost of medical and rehabilitative services provided to injured workers. A few commenters stated that the 20 percent figure in the rule is unrealistically low. In fact, one commenter stated that in the area of workers' compensation, usually 30 percent of services are provided within the network.

A few commenters did not understand the 20 percent limit, and stated that an MCO may be less effective if necessary specialized medical or surgical treatment is denied an injured worker.

A few commenters inquired whether the insurer may exclude the insured's five percent premium reduction or penalize the insured if the insured fails to properly utilize the MCO services, and questioned how and by whom the utilization of MCO services will be monitored.

Another commenter inquired whether the use of authorized non-MCO providers will constitute out-of-network services.

In a related comment, one commenter inquired whether an insurer would be penalized for using more than one MCO where the insurer provides some services in-house and others through a PPO or physicians' network.

RESPONSE: As mentioned in response to a previous comment, the 20 percent standard is intended as a criterion to determine whether the MCO has the ability to offer a broad range of medical services to injured workers. Based on the services provided by the MCO and available in a specific area, an injured employee may be directed outside the MCO network by the MCO itself. This practice may or may not result in exceeding the rule's 20 percent out-of-network limit.

The 20 percent out-of-network limit would not result in an injured employee being denied necessary specialized or surgical treatment. MCOs will be certified only if they contract with an adequate number of specialists as network providers. Nevertheless, when specialized or surgical treatment is necessary and cannot be provided by the network, the MCO will direct the employee to an out-of-network provider.

Insurers will not be penalized for using more than one MCO. In fact, insurers are encouraged to contract for services by using the most cost-effective means. Questions about how an employer may lose the premium discount are beyond the scope of these rules, but may be addressed in the CRIB Manual or in the contracts between the MCO and the insurers.

COMMENT: A few commenters submitted comments on the MCO's geographic service area provision at N.J.A.C. 11:6-2.5(b)2. A few commenters stated that using the county where work sites are located may not provide a worker with convenient access to medical services, leading to increased travel, expense and lost work time for workers. The commenters suggested that providers be located within a 15-mile radius of the work site.

Another commenter suggested that provider services should be offered by ZIP code and/or city since most people do not recognize counties within the State other than the county in which they reside.

One commenter suggested that the MCO certification be on a county-by-county basis if the MCO in New Jersey does not have the capacity to cover the entire State.

RESPONSE: The rule provision at N.J.A.C. 11:6-2.5(b)2 merely requires that an MCO's geographic service area be the county in which the work site is located. The MCO is further required by N.J.A.C. 11:6-2.5(b)3 to provide an adequate number of providers to ensure that covered employers can direct employees to providers located within a reasonable distance from the worksite or, in appropriate cases, closer to the worker's residence. The MCO's approval will, as suggested by the commenter, be on a county-by-county basis. The MCO's provider network will dictate which counties are included in the MCO's approval.

COMMENT: One commenter suggested that any emergency treatment received by an injured worker as set forth at N.J.A.C. 11:6-2.5(b)3i should be paid in full by the insurer regardless of the treating physician's participation status or the facility.

RESPONSE: Emergency medical treatment will be fully covered in accordance with the MCO plan.

COMMENT: A few commenters commented on the requirement at N.J.A.C. 11:6-2.5(b)3ii that workers receive initial treatment by a participating physician within 24 to 72 hours of the MCO's knowledge of the necessity or request for treatment. The commenters stated that this requirement fails to recognize emergency situations where treatment is received by a non-network physician for periods longer than 24 to 72 hours. One commenter suggested that the words "24 hours" be deleted from the rule to cover emergency treatment situations.

RESPONSE: The rule at N.J.A.C. 11:6-2.5(b)3 merely requires that an MCO provider network be adequate to ensure that injured workers can receive emergency treatment as soon as practicable, preferably by a participating physician; that they receive initial treatment by a participating physician within 72 hours depending on the nature of the injury; and that they receive initial treatment by a participating physician in the MCO within five days or as soon thereafter as practicable following treatment by a physician outside the MCO. Accordingly, this last requirement would apply where an injured worker first obtained emergency treatment outside the MCO. The Department agrees with the commenter that the words "24 hours" may be deleted from N.J.A.C. 11:6-2.5(b)3ii without affecting the meaning of that provision. Accordingly, the Department has made the suggested change. In order to provide for maximum utilization of the MCO, the Department expects that an MCO will be

able to arrange for treatment (that is, schedule an appointment) within 24 hours, and may amend these rules to provide that standard.

COMMENT: One commenter suggested that at N.J.A.C. 11:6-2.5(b)3v, the term "medical providers" be replaced by "medical service providers" to be consistent with the rules' definitions.

RESPONSE: The Department agrees with the commenter, and has made the suggested change.

COMMENT: One commenter suggested that at N.J.A.C. 11:6-2.5(b)2, the term "ophthalmologic services," which refers to specialized surgical care and is inconsistent with the context of that particular rule provision, be replaced with "optometric services."

RESPONSE: The Department disagrees. The listing of various types of medical services at N.J.A.C. 11:6-2.5(b)2 merely provides examples of the types of medical services an MCO provides, and is not meant to be exhaustive.

COMMENT: A few commenters commented on the rule provision at N.J.A.C. 11:6-2.5(b)7 requiring the MCO's approval application to include satisfactory evidence of the MCO's ability to meet the financial requirements necessary to ensure delivery of service in accordance with the plan. One commenter stated that solvency monitoring should be guaranteed, and suggested that the MCO contracts be reviewed semi-annually for rate adequacy. Another commenter stated that this requirement would be more appropriate in the HMO arena. Here, the insurer accepts the risk, and the provider would still be available even if the MCO fails unless the MCO operates under the staff model approach.

RESPONSE: The Department agrees that under New Jersey's Workers' Compensation Law, the insurer is always liable for medical treatment regardless of the financial condition of the MCO. Neverthless, the financial requirements placed on the MCO protect insurers planning to contract with a particular MCO.

COMMENT: A few commenters commented on the requirement at N.J.A.C. 11:6-2.5(b)22 that the MCO approval application include the estimated savings in overall premium expected from the use of the MCO. One commenter stated that the MCO may not even be aware of the employer's premium cost or the extent to which the employer will use the MCO. Another commenter stated that the MCO is not qualified to determine the effect on the overall premium since medical is only one component in determining the rate basis. The commenter suggested that the MCO establish the savings in overall medical costs expected and the methodology used to make that determination.

RESPONSE: The Department agrees with the commenters, and has changed the language in the rule to this effect.

COMMENT: One commenter suggested that the MCO certification criteria be tightened to require the MCO to have a minimum number of years experience in the area of workers' compensation.

RESPONSE: The rule requires that the MCO's medical director have a minimum of three years experience in treating either trauma or work-related injuries or illnesses. To impose an additional experience requirement on the MCO would be far too restrictive and may inhibit implementation of the workers' compensation managed care system.

COMMENT: One commenter suggested that the rules require confidentiality of the MCO/insurer contracts required to be submitted to the Department by N.J.A.C. 11:6-2.5(b)16.

RESPONSE: The proposed rules at N.J.A.C. 11:6-2.6 provide for confidentiality of the MCO application.

COMMENT: A few commenters stated that the requirement at N.J.A.C. 11:6-2.5(b)4 that the MCO's approval application include executed copies of the signature page(s) of the contract(s) between the MCO and participating medical service provider/health care provider representative is both costly and burdensome considering the number of providers affiliated with the average MCO, and serves no legitimate purpose. The commenters suggested that the requirement either be eliminated, that these items be submitted only upon request, or that submission of a copy of the MCO's provider directory fulfill the requirement.

RESPONSE: The purpose of the provider contract signature page requirement is to ensure the Department that the providers have, in fact, committed to the MCO. The Department does not believe this requirement is burdensome to the MCOs seeking certification.

COMMENT: One commenter suggested that the Department reconsider including in the rules the provision at N.J.A.C. 11:6-2.5(b)10vi which requires the MCO to have a program whereby a second surgical opinion may be obtained by the worker. The commenter stated that the success of such programs in the workers' compensation area is questionable in that the costs exceed the potential benefits, and suggested that the MCO have the authority to waive the option when justified.

RESPONSE: The rule requires only that an MCO have a "second surgical opinion program which describes the worker's ability to obtain the opinion of a second physician when non-emergency surgery is recommended." The rules do not attempt to dictate the components of such a program. The commenter provides no basis to support his conclusion that the costs of a second surgical opinion program exceed its benefits. As a practical matter, an injured worker cannot be expected to decide whether to undergo surgery without the benefit of a second opinion. Moreover, injured workers are not precluded by these rules from exercising their rights under the Workers' Compensation Law.

COMMENT: One commenter commented on the requirement at N.J.A.C. 11:6-2.5(b)10iii that the MCO peer and utilization program physician profile analysis include the time loss of claimant. The commenter stated that the insurer, not the MCO, possesses that information. The commenter also stated that each MCO's profile analysis should be analyzed on its own merits, and that the model contained in the rule does not necessarily capture the most desirable elements for quality or utilization assessment.

RESPONSE: The Department believes that it is the responsibility of the MCO to gather the information for the physician profile analysis since it is the MCO's responsibility to both provide and control the utilization of physicians. Moreover, the rule merely lists certain elements that the Department believes should be included in the profile analysis. The MCO is free to add to those listed.

COMMENT: One commenter suggested that the responsibility of the MCO set forth at N.J.A.C. 11:6-2.5(b)12 to describe the method whereby the MCO will provide insurers with information to inform employers of all medical service providers within the plan be shared by the insurers.

RESPONSE: The MCO, as the provider of the network, is responsible for providing the insurer with information to be relayed to the insured concerning the method whereby injured employees are to receive medical services. The MCO and the insurer must cooperate with each other in this process.

COMMENT: One commenter stated that N.J.A.C. 11:6-2.5(b)3vi empowers the MCO to create a fee schedule binding on physicians not in the MCO without justification and in direct contravention of the present standard of law.

RESPONSE: The proposed rules do not require that non-MCO providers provide treatment to an injured worker. However, if non-MCO providers opt to treat injured workers under the particular circumstances set forth in N.J.A.C. 11:6-2.5(b)3vi, that provision further requires that they agree to the MCO's terms and conditions for providing such treatment.

COMMENT: One commenter stated that the description of reimbursement procedures for services provided pursuant to the MCO plan requires clarification. The commenter suggested that the MCO be compensated by the percentage of savings generated from the usual and customary fee to the lower contract price (for example, if U&C is $100.00, and the contract price for the provider is $80.00, savings equal $20.00. The MCO would be paid by the insurer a fee as a percentage of the savings).

RESPONSE: These proposed rules provide no description for reimbursement procedures concerning services provided by an MCO. Such procedures are beyond the scope of these rules and would be more appropriately included in the contract between the MCO and the insurer.

COMMENT: One commenter stated that an insurer certified as an MCO should not be permitted to seek contracts or provide services to employers insured with its competitors that also have an MCO within their corporate structure.

RESPONSE: The commenter's concern is beyond the scope of these rules as unrelated to MCO certification.

COMMENT: One commenter stated that the MCO approval application filing fee of $1,500 at N.J.A.C. 11:6-2.9 is excessive, and suggested a one-time fee of between $250.00 to $1,000 would be reasonable and in line with other states.

RESPONSE: The Department believes that the $1,500 application fee is appropriate considering the time and staff level requirements of both the Department of Insurance and the Department of Health in processing the certification applications, the cost of which far exceeds the fee. Additionally, the $1,500 fee furthers the Department's expectation that it will receive applications from only qualified MCOs.

COMMENT: One commenter stated that the rules' Economic Impact statement indicates that implementing a workers' compensation managed

care system will not result in any additional costs to insurers. The commenter suggests that the reduced premium paid by employers opting to use the managed care system will be replaced with the insurer's costs of offering an approved MCO. Therefore, either directly or indirectly, employers will be burdened.

RESPONSE: The Department reiterates its position that with the exception of minimal up-front costs associated with training and implementation, insurers should not incur any additional costs related to the managed care system.

Summary of Changes Upon Adoption:

1. In N.J.A.C. 11:6-2.1(a), the language has been revised to track that contained in the New Jersey Workers' Compensation Law and subsection (b) was added to make clear that these rules are not intended to interfere in any way with the Workers' Compensation Law.
2. The definitions of "health care provider" and "health care services" at N.J.A.C. 11:6-2.2 have been deleted since their intended meanings are duplicative of the definitions of "medical service provider" and "medical services."
3. The definition of "managed care organization" at N.J.A.C. 11:6-2.2 has been revised by adding the words "which may be approved by the Department in accordance with this subchapter." The Department has made this revision recognizing that an MCO under this subchapter serves no legal function or purpose prior to obtaining Department approval. Consistent with this revised definition, the term "approved MCO" appears in the rule where appropriate.
4. The definitions of "medical service" and "medical service provider" at N.J.A.C. 11:6-2.2 have been revised to clarify their intended meaning.
5. The definition of "physician" at N.J.A.C. 11:6-2.2 has been revised to add language clarifying that a physician providing medical services or treatment under these rules, in New Jersey or any other state, must be licensed in the state where such treatment or services are provided.
6. N.J.A.C. 11:6-2.5(a) has been revised to reflect a change in the address where MCO approval applications are to be submitted.
7. N.J.A.C. 11:6-2.5(b)2 has been revised by deleting the words "a minimum of one care coordinator physician for every 1,000 workers covered by the managed care plan" and replacing them with "an adequate number of care coordinator physicians to provide the level and quality of medical treatment and services required under the Workers' Compensation Law."
8. N.J.A.C. 11:6-2.5(b)3ii has been revised to delete the words "24 to" as unnecessary to the meaning of that sentence.
9. N.J.A.C. 11:6-2.5(b)3v has been revised by adding the word "service" in the first sentence so that the term "medical service providers" is consistent with the rules' definitions.
10. N.J.A.C. 11:6-2.5(b)4 has been revised to delete the term "health care provider" since that term has been deleted from the definition.
11. N.J.A.C. 11:6-2.5(b)22 has been revised to delete the term "premium" and insert "medical costs" to clarify that the MCO's reporting responsibility to the insurer does not include estimated savings in overall premium from use of the MCO, but only estimated savings in overall medical costs.
12. N.J.A.C. 11:6-2.7(a)3 has been revised to delete the words "or health care" since the term "health care services" has been deleted from the rules' definitions.
13. N.J.A.C. 11:6-2.7(a)5 has been revised to delete the words "health care provider" and to add "medical service provider" to be consistent with the rules' revised definitions at N.J.A.C. 11:6-2.2.
14. N.J.A.C. 11:6-2.9(a)1 and 2 have been revised by requiring the MCO filing and review fees to be made payable to the Department of Health rather than the Treasurer, State of New Jersey. This change was made in order to facilitate payment of Department of Health's consultation costs.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

SUBCHAPTER 1. (RESERVED)

SUBCHAPTER 2. NEW JERSEY WORKERS' COMPENSATION MANAGED CARE ORGANIZATIONS

11:6-2.1 Purpose and scope

(a) The purpose of this subchapter is to encourage the use of managed care to *[achieve quality care outcomes for the injured worker]* ***furnish injured workers with such medical, surgical and other treatment, and hospital service, as shall be necessary to cure and relieve the worker of the effects of the injury*** and to contain medical costs under workers' compensation coverage by providing eligible employers with a method whereby they may select a managed care alternative to traditional workers' compensation medical care at a reduced premium.

(b) Nothing in this subchapter is intended to revise, rescind or replace any statute under the New Jersey Workers' Compensation Law (N.J.S.A. 34:15-1 et seq.) or any rules of the Division of Workers' Compensation promulgated thereunder.

*[(b)]***(c)*** This subchapter applies to all persons subject to New Jersey's Workers' Compensation Law (N.J.S.A. 34:15-1 et seq.), to all insurers authorized to provide workers' compensation coverage in the State of New Jersey and to all entities seeking approval as a managed care organization under this subchapter.

11:6-2.2 Definitions

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

"Approved managed care organization" means a managed care organization which has been approved by the Department in consultation with the Department of Health.

"Care coordinator physician" means a licensed physician employed by or under contract with, directly or indirectly, the managed care organization, and who is responsible for providing primary medical care to the injured worker, maintaining the continuity of the injured worker's medical care and initiating all referrals to other providers.

"Case manager" means an employee of the managed care organization who is either a licensed registered nurse or a licensed physician, designated to assume responsibility for coordination of services and continuity of care.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Compensation Rating and Inspection Bureau" or "CRIB" means the Bureau created, organized and supervised by the Commissioner of the New Jersey Department of Insurance in accordance with N.J.S.A. 34:15-1 et seq., the New Jersey Workers' Compensation Law.

"Department" means the New Jersey Department of Insurance.

"Employee" or "worker" means an individual covered under a policy of workers' compensation insurance issued pursuant to N.J.S.A. 34:15-1 et seq., the New Jersey Workers' Compensation Law.

"Employer" means an employer obligated under N.J.S.A. 34:15-1 et seq., the New Jersey Workers' Compensation Law, to provide to its employees workers' compensation insurance coverage.

*["Health care provider" means an entity or group of entities, organized to provide health care services or organized to provide administrative support services to those entities providing health care services.

"Health care services" means medical or surgical treatment, nursing, hospital and optometrical services.]*

"Insured" means any employer obligated under the New Jersey Workers' Compensation Law to be insured under a policy of workers' compensation insurance issued by an insurer authorized to write workers' compensation insurance in the State of New Jersey.

"Insurer" means any insurer authorized to write workers' compensation insurance in the State of New Jersey.

"Managed care organization" or "MCO" means any entity that manages the utilization of care and costs associated with claims covered by workers' compensation insurance***, which may be approved by the Department in accordance with this subchapter****.

"Medical director" means a licensed physician, board certified in occupational medicine, internal medicine, orthopedics, neurosurgery, neurology or related fields, having a minimum of three years experience in treating either trauma or work-related injuries or illnesses, who is employed by the MCO for the primary purpose of providing full-time, day-to-day direction, management and supervision of medical care.

"Medical service" means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or related services *[such as]* ***or*** any medication, crutch, prosthesis, brace, support or physical restorative device.

"Medical service provider" or "provider" means any physician, hospital or other person ***or entity*** licensed or otherwise authorized by any state to furnish medical services.

"Participating physician" or "participating provider" means a health care physician or provider who is under contract, directly or indirectly, with a managed care organization.

"Physician" means a person duly licensed by ***the State of New Jersey or by*** any ***other*** state to practice one or more of the healing arts in that state within the limits of the license of the licentiate.

"Report" means medical information transmitted in written form containing relevant subjective and objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the Department or the Department of Health.

11:6-2.3 Approval of managed care organizations

(a) The completion by an MCO of the approval process conducted by the Department, in consultation with the Department of Health, under this subchapter shall authorize the ***approved*** MCO to provide medical services under a workers' compensation policy after the insurer has filed an application with CRIB to obtain approval of a minimum five percent overall premium reduction for the insured's election to use a Department-approved managed care system for workers' compensation medical coverage. An approval issued under this subchapter shall not be used for any purpose except as set forth in this subchapter.

(b) The approval issued to an MCO under this subchapter by the Department in consultation with the Department of Health shall remain in force for a period of two years excepting suspension or revocation pursuant to this subchapter.

11:6-2.4 Requirements of approved managed care organizations

(a) For purposes of providing medical services to injured workers under a workers' compensation insurance policy as set forth in this subchapter, an MCO shall meet the following criteria:

1. The MCO shall arrange for the full range of medical and rehabilitative services necessary to treat injured workers, including, but not limited to, primary care, orthopedic care, inpatient care, emergency care, physical therapy and occupational therapy. In the aggregate, services provided outside of the MCO network should not exceed 20 percent of the MCO's cost of medical and rehabilitative services provided to injured workers.

2. The MCO shall provide geographic access by county to emergency, medical and rehabilitative services for employer sites covered under its program. Such services may be delivered directly, under contract, or through written referral protocol;

3. The MCO shall have medical care direction provided and supported by medical directors as defined in this subchapter;

4. The MCO shall provide medical management, catastrophic case management, disability case management and monitoring. These case management services must be supported by documented medical and disability protocol and should be generally accepted by the medical community;

5. The MCO shall track and manage an injured worker's progress from the onset of injury through case resolution;

6. The MCO shall contract with participating health care and rehabilitation providers who are credentialed by the MCO according to their documented criteria, which must specifically include the provider's ability to handle workplace injuries and illnesses;

7. The MCO shall provide written dispute resolution and grievance procedures to assure that disagreements with medical providers are resolved without jeopardizing or disrupting patient management;

8. The MCO shall provide reports as may be required by the Commissioner in areas including, but not limited to, medical utilization, disability data and costs of the MCO;

9. The MCO shall possess the resources, financial and otherwise, necessary to sustain required services; and

10. The MCO shall have a fraud detection plan, which shall include, but not be limited to, measures for detecting and reporting instances of possible fraud on the part of injured workers, employers, medical providers and others. The MCO shall coordinate its fraud detection plan with the workers' compensation insurer's fraud prevention plan, where appropriate.

11:6-2.5 Managed care organizations approval procedures

(a) For purposes of obtaining the Commissioner's approval under this subchapter, an MCO shall submit *[four]* ***two*** copies ***each*** of a written application to the Department ***and the Department of Health*** at the following address***es***:

Managed Health Care Bureau
Actuarial Services, Life/Health
N.J. Department of Insurance
20 West State Street
CN 325
Trenton, NJ 08625

Alternative Health Systems Program
N.J. Department of Health
300 Whitehead Road
CN 367
Trenton, NJ 08625

(b) The MCO application shall include the following:

1. A list of the names, addresses, and specialities of the individuals, rehabilitation centers, hospitals and other centers and clinics that will provide services under the managed care plan. This list shall indicate which medical service providers will act as care coordinator physicians within the MCO. In addition, the MCO shall provide a map of the service area, indicating the location of the providers by type;

2. A narrative description of the places and protocol of providing services under the plan, including a description of the initial geographical service area. The geographical service area shall be designated as the county in which work sites are located; a description of the number and type of disciplines of medical service providers to treat work-related injuries and illnesses, such as orthopedic, chiropractic, dental and ophthalmologic services; and a description of the number of care coordinator physicians in the MCO. The MCO shall maintain *[a minimum of one care coordinator physician for every 1,000 workers covered by the managed care plan]* ***an adequate number of care coordinator physicians to provide the level and quality of medical treatment and services as required under the Workers' Compensation Law***. The requirements of this paragraph shall be met unless the MCO adequately demonstrates the unavailability of a particular type of provider in a particular geographic service area;

3. A description of the MCO treatment standards and protocols that will govern the medical treatment provided by all medical service providers, including care coordinator physicians. The number of providers should be adequate as necessary to ensure that workers of employers covered by the MCO can:

i. Receive emergency treatment as soon as practicable, preferably by a participating physician;

ii. Receive initial treatment by a participating physician within *[24 to]* 72 hours (depending on the nature of the injury or illness) of the MCO's knowledge of the necessity or request for treatment;

iii. Receive initial treatment by a participating physician in the MCO within five working days or as soon thereafter as practicable, following treatment by a physician outside the MCO;

iv. Receive screening and treatment if necessary by an MCO physician in cases requiring in-patient hospitalization;

v. Be directed to medical ***service*** providers within a reasonable distance from the worker's place of employment, considering the nature of care required and normal patterns of travel. To receive urgent care, the worker shall be assigned to a physician near the workplace. The assigned care coordinator physician will, in turn, arrange for necessary care through a provider closer to the worker's residence, if appropriate;

vi. Receive treatment by a non-MCO medical service provider at the direction of the care coordinator physician when the worker resides outside the MCO's geographical service area. The care coordinator physician may only select a non-MCO provider who practices closer to the worker's residence than an MCO provider of the same category if that non-MCO provider agrees to the terms and conditions of the MCO; and

vii. Receive specialized medical services the MCO is not otherwise able to provide. The MCO's application shall include a description of the places and protocol of providing such specialized medical services;

4. Specimen copies of contract(s), agreement(s), or other documents between the MCO and each participating medical service provider*[/health care provider]* representative, and executed copies of the signature page(s) of such contract, agreement or other document for each provider;

5. The identity of a communication liaison for the Department, employer, worker and the insurer at the MCO's location. The responsibilities of the liaison shall include, but not be limited to, responding to questions and providing direction regarding outgoing correspondence, medical bills, case management and medical services;

6. A description of the reimbursement procedures for all services provided in accordance with the MCO plan;

7. Satisfactory evidence of the MCO's ability to meet the financial requirements necessary to ensure delivery of service in accordance with the plan;

8. A description of the MCO's quality assurance program which shall include, but is not limited to:

i. A system for resolution and monitoring of problems and complaints, including, but not limited to, the problems and complaints of workers;

ii. A program which specifies the criteria and process for physician peer review; and

iii. A standardized claimant medical recordkeeping system designed to facilitate entry of information into computerized databases for purposes of quality assurance;

9. A program under the direction of a case manager involving cooperative efforts by the workers, the employer, the insurer, and the managed care organization to promote early return to work for injured workers;

10. A program which provides adequate methods of peer review and utilization review to prevent inappropriate or excessive treatment, including, but not limited to:

i. A pre-admission review program, which requires physicians to obtain prior approval from the MCO for all non-emergency admissions to the hospital and for all non-emergency surgeries prior to surgery being performed;

ii. Individual case management programs, which search for ways to provide appropriate care at lower cost for cases which are likely to prove very costly, such as physical rehabilitation or psychiatric care;

iii. Physician profile analysis which shall include such information as each physician's total charges; number and costs of related services provided; time loss of claimant; and total number of visits in relation to care provided by other physicians with the same diagnosis;

iv. Concurrent review programs, which periodically review the worker's care after treatment has begun, to determine if continued care is medically necessary;

v. Retrospective review programs, which examine the worker's care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate; and

vi. Second surgical opinion programs which describe the worker's ability to obtain the opinion of a second physician when non-emergency surgery is recommended;

11. A procedure for internal dispute resolution, in coordination with the insurer, which shall include a method to resolve complaints by injured workers, medical providers and employers;

12. A description of the method whereby the MCO will provide insurers with information to inform employers of all medical service providers within the plan and the method whereby workers may be directed to those providers;

13. Copies of the MCO certificate of incorporation and/or by-laws indicating managed care responsibilities, if applicable;

14. A general diagram of the MCO's managed care organizational structure;

15. The location of the place of business where the MCO administers the plan and maintains its records;

16. Copies of executed contracts between the MCO and insurer, if applicable;

17. A listing and biography of the MCO's officers and directors, or the individuals within the MCO responsible for managed care;

18. Evidence of or the MCO's certification of malpractice insurance for each provider;

19. The MCO's most recently audited financial report or its capitalization and projections if a newly organized MCO;

20. A detailed description of the MCO's experience with the management of health care costs associated with workers' compensation claims and with other health care claims;

21. A copy of the certificate of the board certified medical director;

22. The estimated savings in overall *[premium]* ***medical costs*** expected from the use of the MCO and the methodology used in arriving at such estimate;

23. The outline of the operation of the MCO to be provided to employers explaining their rights and responsibilities; and

24. Any other materials specifically requested by the Commissioner or the Commissioner of Health in connection with a particular application.

(c) The materials specified in (b) above shall be retained by the Department and referred to the Department of Health for consultation as necessary. Any significant changes to the nature of the MCO's operations as reflected in these materials shall be reported to the Department within 30 days.

(d) The Department, in consultation with the Department of Health, shall review these documents and grant approval, within 45 days of the MCO's filing its application, to those MCOs deemed to meet the criteria set forth in this subchapter. The Commissioner may extend the 45-day time frame an additional 30 days for good cause shown and shall provide notice to the MCO of such extension. A decision to deny approval shall be accompanied by a written explanation by the Department of the reasons for denial.

(e) An ***approved*** MCO shall apply for renewal of its Department approval biannually.

11:6-2.6 Confidentiality of MCO application

(a) All data or information contained in the MCO's application for approval as set forth in N.J.A.C. 11:6-2.5(b) is confidential and will not be disclosed by the Department or the Department of Health to any person other than their employees and representatives, except the following items, but only upon written, specified request and upon notice to the MCO:

1. A description of the MCO's current and prior authority to do business in the State of New Jersey;

2. An organizational chart;

3. A listing and biography of the MCO's officers and directors;

4. The address of the MCO's place of business;

5. The identity of the MCO communication liaison;

6. MCO audited financial reports, capitalization or projections, if otherwise available as filed with any other state or Federal government agency; and

7. The certificate of MCO's board certified medical director.

11:6-2.7 Approval suspension and revocation

(a) The approval of an MCO issued by the Department under this subchapter may be suspended or revoked if:

1. The Department determines that the MCO criteria set forth in this subchapter are no longer being met;

2. Service under the plan is not being provided in accordance with the terms of the approved plan;

3. The plan for providing medical *[or health care]* services fails to meet the requirements of these rules;

4. Any false or misleading information is submitted by the MCO or any member of the organization;

5. The ***approved*** MCO continues to utilize the services of a *[health care]* ***medical service*** provider whose license has been suspended or revoked by the licensing board; or

6. The ***approved*** MCO fails to reduce losses sufficiently to produce a five percent premium credit.

(b) If the Commissioner denies MCO approval under this subchapter or suspends or revokes MCO approval for any of the reasons set forth in this subsection, the MCO may request a hearing on the Commissioner's determination within 10 days from the date of receipt of such determination.

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

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

ii. A copy of the Commissioner's written determination;

iii. A statement requesting a hearing; and

iv. A concise statement describing the basis for which the MCO 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 an informal conference between the MCO and such personnel of the Department or Department of Health as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

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 there are no good-faith disputed issues of material fact and the matter may be decided on the documents filed, the Commissioner shall notify the MCO in writing of the final disposition of the matter.

ii. 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.

11:6-2.8 Monitoring; auditing

(a) The Department, together with the Department of Health, shall monitor and conduct periodic audits of the ***approved*** MCO as necessary to ensure compliance with the MCO approval criteria set forth in this subchapter.

(b) All records of the ***approved*** MCO and its individual participating physicians or providers shall be disclosed upon request of and in a format acceptable to the Commissioner. If such records are maintained in a coded or semi-coded manner, a legend for the codes shall be provided to the Commissioner.

11:6-2.9 Filing and review fees

(a) Every MCO filing for approval of its managed care program under the procedures set forth in N.J.A.C. 11:6-2.5 shall pay the following fees:

1. An approval application fee of $1,500 payable to *["Treasurer, State of New Jersey."]* ***"Department of Health."***

2. A biannual approval renewal fee of $1,000 payable to *["Treasurer, State of New Jersey."]* ***Department of Health."***

LABOR

(a)

DIVISION OF WORKPLACE STANDARDS

Safety and Health Standards for Public Employees Occupational Exposure to Bloodborne Pathogens

Adopted Amendment: N.J.A.C. 12:100-4.2

Proposed: October 19, 1992 at 24 N.J.R. 3607(b).

Adopted: June 8, 1993 by Raymond L. Bramucci, Commissioner, Department of Labor.

Filed: June 8, 1993 as R.1993 d.323, **with technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 34:1-20, 34:1A-3(e) and 34:6A-25 et seq., specifically 34:6A-30, 31 and 32.

Effective Date: July 6, 1993.

Expiration Date: September 22, 1994.

On October 19, 1992 at 24 N.J.R. 3607(b), the Department of Labor proposed an amendment to N.J.A.C. 12:100-4.2 covering occupational exposure to bloodborne pathogens. The standard provides for the protection of public employees who could reasonably be expected to come into contact with human blood and other potentially infectious materials in the course of their work. The standard requires more abatement methods than those required under the General Duty Clause and the General Industry Standards now found at N.J.A.C. 12:100-4.2. The standard gives employers and employees more guidance in carrying out the goal of reducing the risk of occupational exposure to bloodborne pathogens.

Comments on the proposal were received from 20 commenters during the public comment period which ended on November 18, 1992; additional comments were thereafter received from two commenters and are responded to herein. The following is a list of organizations which have submitted written comments directly related to the proposed amendment:

1. American Federation of Teachers/New Jersey
2. Atlantic County, Richard E. Squires, County Executive
3. Atlantic County Special Services School District
4. Communications Workers of America
5. Englewood Professional Fire Fighters, International Association of Fire Fighters, Local 3260
6. Fire Fighters Association of New Jersey, International Association of Fire Fighters
7. Government Finance Officers' Association of New Jersey
8. Middletown Department of Health
9. Monmouth County Health Officers Association, Inc.
10. National Association of County Health Officials
11. Newark Fire Officers Union, International Association of Fire Fighters, Local 1860
12. New Jersey Association of County Health Officers
13. New Jersey Department of Corrections
14. New Jersey Health Officers Association
15. New Jersey State First Aid Council
16. New Jersey State Nurses Association
17. New Jersey Transit
18. Ocean County Health Department
19. Piscataway Department of Health
20. Professional Fire Officers Association
21. Professional Health Officers Society of New Jersey
22. Teaneck Fire Department

Several commenters dealt with multiple issues and, in a few cases, more than one commenter addressed the same issue. A full record of the opportunity to be heard can be inspected by contacting the Office of External and Regulatory Affairs, New Jersey Department of Labor, CN 110, Trenton, New Jersey 08625.

Summary of Public Comments and Agency Responses:

COMMENT: Several of the commenters expressed approval of the standard and supported its immediate adoption, including the proposed implementation schedule which tracks the Federal standard.

RESPONSE: The Department acknowledges the commenters' support of the new standard on occupational exposure to bloodborne pathogens.

COMMENT: A review of the OSHA docket on the 25 CFR 1910.1030 standard will verify the need and support for the immediate adoption of that standard as it is now written. Employers and employees in both the public and private sectors have been made aware of the issues since 1989 and the standard has been in effect in the private sector since December 1991. Therefore, there is no reason for further delay in adopting the standard in the public sector in New Jersey.

RESPONSE: The Federal record on this rulemaking activity contains comments and testimony from over 3,000 interested parties, all of which were considered over a four year period from 1987 to 1991. Those comments and testimony covered a wide range of industries and occupations including those in the public sector, such as police, firefighters, corrections officers, health providers and emergency responders. The final standard, 29 CFR 1910.1030, represents the outcome of the Federal rule-making activity.

After having carefully reviewed the Federal activity relating to occupational exposure to bloodborne pathogens, the Department agrees that the OSHA docket on 29 CFR 1910.1030 contains sufficient evidence to support the adoption of the standard. The Department, as did Federal OSHA, has determined that the standard should provide for a staggered implementation schedule in recognition of necessary start-up activities and budgetary processes which may need to be addressed by municipalities, counties and other public employers in order to comply with the standard's mandates.

COMMENT: The standard calls for "the protection of all employees who could reasonably be anticipated to come into contact with human blood and other potentially infectious material in the course of their work." The OSHA standard does not define "reasonably be anticipated." The absence of such a definition may result in inappropriate or inconsistent applications of the standard.

RESPONSE: The department has determined that a reasonableness standard is sufficient for the effective implementation of the standard. In addition, because the Department has a statutory duty to adopt standards which afford at least the same level of protection as that provided under the Federal OSHA standards, a definition of the term may inadvertently provide less protection. It should be noted that determinations made by public employers are subject to appeal and this review will provide the necessary consistency for the effective implementation of the standard.

COMMENT: Employees should be categorized into three groups, "high risk," "intermediate risk" and "low risk," with the first group being offered inoculation, the second group given only post-exposure treatment and the third group not offered inoculation at all.

RESPONSE: Pursuant to N.J.S.A. 34:6A-30, the Department may not adopt standards which provide less protection than that provided by Federal OSHA. Accordingly, the Department does not propose to establish by regulation any additional categories which would result in less protection of public employees than employees in similar occupations in the private sector.

COMMENT: The severe financial burden of compliance imposed by the standard should be alleviated by extending the time for compliance at least one year beyond the adoption of the regulation.

RESPONSE: The timeframe from October 19, 1992, the date of the proposal's publication, to the date by which full compliance with the standard must be achieved is within the period sought in the comment.

COMMENT: A hospital should be required to notify the emergency responders that a client who has been delivered to the hospital has tested positive for the HIV or the HBV pathogens.

RESPONSE: The Department does not have the authority to impose regulations which would abrogate the right to privacy afforded an individual under the law. Accordingly, the proposed suggestion may not be incorporated in the standard.

COMMENT: The implementation of the regulation should be delayed at least 12 months to minimize the impact upon government agency budgets and taxpayers.

RESPONSE: The Department has been aware of this concern and has been advising public employers of the impending regulation since the adoption by the Federal OSHA of the standard in December 1991. Moreover, in recognition of the adverse financial impact compliance with these regulatory requirements may have on public employers, a staggered schedule for compliance has been devised. In addition, the Department will be filing the requisite certification with the Local Finance Board of the Department of Community Affairs to facilitate that department's exception of compliance-related expenditures from the local government spending limitations pursuant to N.J.S.A. 40A:4-45.3. As a result of the Department's actions, public employers have had a reasonable opportunity to address budgetary considerations and no further delay is appropriate.

COMMENT: The effective date of the regulation should be made commensurate with the ability of the Human Resources and Development Institute to develop and provide the training required.

RESPONSE: The affected public has been aware of the standard since 1989 and it has been in effect in the private sector since 1991. Thus, since the introduction of the standard, there has been sufficient time for the development of trainers and training programs. Furthermore, the timeframe contained in the proposal provides adequate time for the development, if necessary, of training programs tailored to the public sector.

COMMENT: There is no epidemiological evidence to demonstrate that police officers, firemen or correctional facility personnel are at an increased risk of contracting Hepatitis B. These groups of employees could be adequately protected by post-exposure treatment on a case-by-case basis.

RESPONSE: The New Jersey Department of Health reports that in its Hepatitis B surveillance system, the occupations referred to in the comment are not categorized separately, but are listed in the "other" category. The Department of Health has deferred to the conclusions reached by OSHA that these occupations are indeed at risk as a result of occupational exposure. The data used by OSHA are presented in the December 6, 1991 Federal Register notice in both Section IV, "Health Effects" and Section V, "Quantitative Risk Assessment." Accordingly, the Department does not consider it appropriate to include such groups in a suggested "Minor Risk" category. Furthermore, under the legislative mandate set forth at N.J.S.A. 34:6A-30, the Department may not reduce or provide less protection than is provided by Federal OSHA. Accordingly, the Department considers it prudent to follow the conclusions reached by OSHA in its enforcement of the proposed regulation.

COMMENT: The costs associated with this regulation should be outside the municipal spending cap and this should be clearly defined in this regulation.

RESPONSE: Mandated expenditures imposed upon municipalities for such occupational health and safety requirements may be excepted from the spending caps referenced in the comment. To facilitate the granting of the exception, the Department will be filing a statement, along with a copy of the regulations, with the Local Finance Board of the Department of Community Affairs certifying that the requirements of the new standard constitute a mandatory expenditure for public employers. However, because the authority to except expenditures from the spending limitations resides outside of this Department, the Department will be unable to adopt a rule to that effect.

COMMENT: Exposure of the fire service occurs in a virtually uncontrolled environment; therefore, the State should provide specific training tailored to these types of incidences.

RESPONSE: As stated by Federal OSHA, it is the responsibility of the public employer to provide a training program tailored to the occupational conditions to which the employee is exposed and to verify the competency of the trainers based upon the completion of specialized courses or degree programs or work experience. The training program will be evaluated by compliance officers on a case-by-case basis due to the wide range of work practices involved to determine the adequacy and effectiveness of the training provided.

COMMENT: An agency which has already instituted most of the practices and procedures of the new standard, including the vaccination procedures, has asked if under the standard it would be satisfactory to provide employees with a written training program which employees could complete, sign and return to the agency medical department. The agency also would designate a trainer with a designated phone line to answer employee questions.

RESPONSE: The Department acknowledges the agency's actions as supporting the regulation; however, with regard to the training described in the comment, the standard specifically provides for the opportunity for interactive questions and answers with the person conducting the training session. Therefore, the proposed training would not satisfy the standard.

COMMENT: A better definition of "reasonably anticipated" occupational exposure is needed. "Frequency of exposure" should be used as a criterion in the definition.

RESPONSE: The testimony made available in the OSHA docket clearly shows that a single incident of exposure can result in infection from the pathogens. Accordingly, it would be misleading for the Department to support the concept of "frequency of exposure."

COMMENT: The published rules should include a definition for public employers describing which workers they can reasonably anticipate will be exposed to blood or other potentially infectious materials in the performance of their tasks.

RESPONSE: The proposed regulation establishes that each employer shall establish a written Exposure Control Plan which shall list the job classifications in which exposure occurs and list the tasks and procedures during which exposure occurs. Because of the wide range of classifications involved throughout the entire public sector, the job classifications are best established by each employer for that employer's specific workplace. The Department could not adequately categorize each workplace and each job classification by regulation without unduly delaying the implementation of the standard.

COMMENT: The cost of the vaccine for HBV has a considerable economic impact on a public employer and the State should subsidize a municipality's total costs for the vaccine.

RESPONSE: Public employers have access to a State contract number through which the vaccines may be obtained from the manufacturer at a favorable price. This will serve to alleviate the economic burden on the public employer.

COMMENT: The effective dates for the individual components of the regulation, such as the exposure control plan and training requirements, far exceed the time limits set by the Federal standard for the private sector. Under the proposed standard, the public employers have more than twice as long as private employers to comply with the standard.

RESPONSE: The proposed time schedule for the rules is identical to that followed by Federal OSHA. The regulation will become operative 90 days after the notice of adoption is published in the New Jersey Register, with the various components of the standard being phased in over four, five and seven months from the date of publication. The Department can not set the same actual dates as Federal OSHA did in the private sector because the dates applicable to the private sector predate the adoption of the rule in the public sector.

COMMENT: The standard should articulate whether volunteers in the emergency medical service field are regarded as employees of the municipality under the standard.

RESPONSE: Since the promulgation of the rules under the Public Employees Occupational Safety and Health Act (PEOSHA), the Department has included volunteers under the Act's coverage. The Federal OSHA has also not considered volunteers to be in the private sector.

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

(Agency Note: By amendment effective April 19, 1993, the reference date in N.J.A.C. 12:100-4.2(a) was changed to May 27, 1992. That date is retained in the rule as published below, with the Federal Standards adopted herein effective December 6, 1991.)

12:100-4.2 Adoption by reference

(a) The standards contained in 29 CFR Part 1910, General Industry Standards, with amendments published in the Federal Register through May 27, 1992 with certain exceptions noted in (b) and (c) below are adopted and are incorporated herein by reference as occupational health standards for the protection of public employees engaged in general operations and shall include:

1.-18. (No change.)

19. Subpart Z—Toxic and Hazardous Substances.

i. As incorporated herein by reference, 29 CFR Part 1910.1030 shall become operative *[(90 days after the effective date of this amendment)]* ***October 4, 1993***, with the following exceptions:

(1) The exposure control plan required by 29 CFR Part 1910.1030(c)2 shall be completed on or before *[(150 days after the effective date of this amendment)]* ***December 3, 1993***;

(2) The information and training required by 29 CFR Part 1910.1030(g)2 and the recordkeeping required by 29 CFR Part 1910.1030(h) shall become operative *[(six calendar months after the effective date of this amendment)]* ***January 6, 1994***; and

(3) 29 CFR Part 1910.1030(d)2, (d)3, (d)4, (e), (f) and (g) shall become operative *[(seven calendar months after the effective date of this amendment)]* ***February 6, 1994***.

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

(a)

DIVISION OF WORKPLACE STANDARDS

Carnival Amusement Rides

Readoption with Amendments: N.J.A.C. 12:195

Proposed: May 3, 1993 at 25 N.J.R. 1832(a).

Adopted: June 14, 1993 by Raymond L. Bramucci, Commissioner, Department of Labor.

Filed: June 14, 1993 as R.1993 d.343, **without change.**

Authority: N.J.S.A. 5:3-31 et seq., specifically N.J.S.A. 5:3-36.

Effective Date: June 14, 1993, Readoption.
July 6, 1993, Amendments.

Expiration Date: June 14, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 12:195.

Full text of the adopted amendments follows.

12:195-1.4 Documents referred to by reference

(a) (No change.)

(b) The standards listed below have been utilized in the development of this rule, when appropriate:

1. ASTM F698-1988, Physical Information to be provided for Amusement Rides and Devices;

2. ASTM F747-1989, Definitions of Terms Relating to Amusement Rides and Devices;

3. ASTM F770-1988, Practice for Operation Procedures for Amusement Rides and Devices;

4. ASTM F846-1992, Guide for Testing Performance of Amusement Rides and Devices;

5. ASTM F853-1991, Practice for Maintenance Procedures for Amusement Rides and Devices; and

6. (No change.)

12:195-6.1 Documents referred to by reference

(a) The full title and edition of each of the standards and publications referred to in this chapter is as follows:

1. (No change.)

2. ASTM F698-1988, Physical Information to be provided for Amusement Rides and Devices;

3. ASTM F747-1989, Definitions of Terms Relating to Amusement Rides and Devices;

4. ASTM F770-1988, Practice for Operation Procedures for Amusement Rides and Devices;

5. ASTM F846-1992, Guide for Testing Performance of Amusement Rides and Devices;

6. ASTM F853-1991, Practice for Maintenance Procedures for Amusement Rides and Devices;

7.-14. (No change.)

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CRIMINAL JUSTICE POLICE TRAINING COMMISSION

Police Training Commission Rules

Readoption with Amendments: N.J.A.C. 13:1

Proposed: April 5, 1993 at 25 N.J.R. 1336(a).
Adopted: June 2, 1993 by Police Training Commission, Wayne S. Fisher, Ph.D., Chairman and Deputy Director, Division of Criminal Justice.
Filed: June 9, 1993 as R.1993 d.325, **without change**.

Authority: N.J.S.A. 52:17B-71(h).

Effective Date: June 9, 1993, Readoption;
July 6, 1993, Amendments.
Expiration Date: June 9, 1998.

Summary of Public Comments and Agency Responses:
During the comment period the Commission received one letter from Paul D. Roman, EMS Training Coordinator, Monmouth County Police Academy.

COMMENT: There should be one term to describe all Commission approved police training instructors.

RESPONSE: The distinction between police officer instructors and special instructors was created specifically in order to encourage participation by civilian instructors, such as doctors and lawyers, without requiring them to attend a five day long course in methods of instruction.

Full text of the readoption can be found in the New Jersey Administrtative Code at N.J.A.C. 13:1.

Full text of the adopted amendments follows.

13:1-1.1 Definitions

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

...

"Appointing authority" means a person or group of persons having the power of appointment to or removal from offices, positions or employment as police officers, corrections officers and juvenile detention officers.

...

"In-service course" means any Commission-approved course of study which a police officer, corrections officer or juvenile detention officer shall attend after completion of the basic course.

...

"Law enforcement agency" means any police force, corrections authority or organization functioning within this State, except for the Division of State Police and any Federal or a bi-state police force, which has by statute or ordinance the responsibility of detecting crime and enforcing the criminal or penal laws of this State.

...

"Police instructor" means an individual who is employed as a police officer as defined in this subchapter and is certified by the Commission to teach at a Commission-approved school.

"Police officer" means any employee of a law enforcement agency, other than a civilian employee, any member of a fire department or force who is assigned to an arson investigation unit pursuant to Public Law 1981, Chapter 409 and any corrections officer or juvenile detention officer. A "juvenile detention officer" includes one who is involved with the custody of juvenile offenders of the law who performs his or her duties in residential facilities.

...

"Special instructor" means a civilian who is not employed as a police officer as defined in this subchapter and is certified by the Commission to teach in a Commission-approved school.

...

13:1-3.4 Application review

The Commission staff shall review the application to determine if the applicant has demonstrated a need for the school, shall inspect the facility where the training is to be conducted and determine if the applicant has the necessary resources to operate the school. The Commission staff shall submit a written report to the Commission which shall contain a recommendation with respect to the request. The Commission shall approve or disapprove the certification request with any conditions it believes to be appropriate.

13:1-3.5 Hearing on application

In the event a law enforcement agency interposes an objection with respect to school certification or there is more than one application for certification of a school within the same or adjoining counties the Commission staff may, for good cause, schedule a hearing by the Commission on the matter after due notice to the affected parties. The Commission shall approve or disapprove the certification request with any conditions it believes to be appropriate.

13:1-3.6 School recertification

Initial certification or recertification of a school by the Commission shall be for a period of three years. An application for recertification shall be the same as that provided in N.J.A.C. 13:1-3.2 through 3.5 together with a Commission staff determination that a school has complied with all Commission requirements.

13:1-4.1 Certification requirement

All instructors participating in a course authorized by the Commission must be certified before they are permitted to teach except as set forth in this subchapter and except as provided for in an emergency as set forth in N.J.A.C. 13:1-7.2(a)14.

13:1-4.5 Certification

(a) Initial instructor certifications and renewals thereof shall expire on December 31 of the third year after the granting or renewal of the certifications. As a condition of recertification, an instructor must teach at least once during the prior certification period.

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

13:1-5.1 Certification requirements; basic courses

(a) A trainee shall be eligible for certification when the school director affirms that:

1. The trainee has achieved the minimum requirements set forth in the Basic Course for Police Officers, the Basic Course for Investigators, the Basic Course for Special Law Enforcement Officers, the Basic Course for Corrections Officers, the Basic Course for Juvenile Detention Officers, the Basic Course for County Park Rangers or the Basic Course for Juvenile Residential and Day Program Youth Workers and has demonstrated an acceptable degree of proficiency in the performance objectives contained therein;

2.-3. (No change.)

13:1-6.1 Curriculum and courses

A curriculum promulgated by the Commission shall be the required curriculum at a Commission-approved school. The Commission curricula are incorporated herein by reference and are available from the Commission at the Richard J. Hughes Justice Complex, CN-085, Trenton, New Jersey 08625. An approved school shall conduct basic courses and those other courses as shall be required by the Commission. In addition to the required curriculum, a school may also offer, with Commission staff approval, additional components of a basic course.

13:1-7.2 Operating entity responsibilities

(a) The law enforcement agency, combination of law enforcement agencies, institution of higher learning, or recognized governmental entity certified to operate a school is vested with the power, responsibility and duty:

1.-6. (No change.)

7. To report immediately the illness or injury of a trainer or an instructor to an appropriate official in the trainee's or instructor's law enforcement agency and to the Commission staff;

8. To dismiss a trainee who has demonstrated that he or she will be ineligible for Commission certification, for unacceptable behavior or for other good cause. In such cases:

i. The trainee shall be informed immediately of the reason(s) for the action;

ii. As soon as possible, but in no event later than the second business day thereafter, a written statement of the reason(s) for the action shall be provided to the trainee, the appropriate official in the trainee's law enforcement agency and the Commission;

iii. The dismissal of a trainee for misconduct may take effect immediately when, in the opinion of the school director, the continued presence of the trainee would be disruptive of or detrimental to the conduct of the class;

iv. Upon the written request of a trainee, the Commission Chairman may, after consultation with the school director and for good cause, permit a trainee to remain in school pending the appeal of a dismissal pursuant to N.J.A.C. 13:1-9;

v. A trainee who is dismissed from a school for misconduct shall not receive credit for any subjects completed up to the time of dismissal;

9.-12. (No change.)

13. To verify that all instructors have Commission certification. In an emergency or compelling circumstances, a non-certified instructor may be used. In such event the Commission staff shall be notified as soon as possible and prior to any teaching by such individual and informed of the reason for this exception;

Recodify existing 15 to 19 as 14 to 18. (No change in text.)

19. To conduct drug screening of all trainees so as to provide for the safety and welfare of all trainees, instructors and other school personnel in accordance with the following procedures:

i. All trainees will be requested to sign a notice and acknowledgment in a form prescribed by the Commission consenting to the sampling and testing of urine during the course. This notice and acknowledgment will include notification that a positive confirmation of the presence of illegal drugs in the trainee's urine will result in dismissal from the school;

ii.-iv. (No change.)

v. Trainees will be required to submit urine samples during the course;

vi.-xiii. (No change.)

xiv. The school director shall dismiss any trainee who produces a positive test result for illegal drug usage. Such dismissal shall constitute a dismissal for misconduct; and

xv. The Commission may, as circumstances warrant, notify the central registry maintained by the Division of State Police of a trainee's positive test result for illegal drug usage.

Recodify existing 21 to 23 as 20 to 22. (No change in text.)

13:1-8.4 Waivers

(a) (No change.)

(b) A request to waive training shall be submitted by the appointing authority to the Commission on a form prescribed by the Commission together with official documentation from the institution where the training was obtained.

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

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF DENTISTRY

Advertising

Adopted Amendment: N.J.A.C. 13:30-8.6

Proposed: August 17, 1992 at 24 N.J.R. 2801(a).

Adopted: May 10, 1993 by the State Board of Dentistry, Jerome Horowitz, D.D.S., President.

Filed: June 3, 1993 as R.1993 d.332, **with a substantive change** not requiring additional public notice and comment **and with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 45:6-3.

Effective Date: July 6, 1993.

Expiration Date: March 12, 1995.

The State Board of Dentistry afforded all interested parties an opportunity to comment on the proposed amendment, N.J.A.C. 13:30-8.6, relating to professional advertising. The official comment period ended on September 16, 1992. Announcement of the opportunity to respond to the Board appeared in the New Jersey Register on August 17, 1992 at 24 N.J.R. 2801(a). Announcements were also forwarded to: Newark Star Ledger, Trenton Times, Asbury Park Press, Courier Post, Bergen Record, New Jersey Dental Association, New Jersey Hospital Association, New Jersey Dental Assistant Association, American Dental Hygiene Association, New Jersey Department of Health, and to other interested individuals and organizations.

A full record of this opportunity to be heard can be inspected by contacting the Board of Dentistry, 124 Halsey Street, Newark, New Jersey 07102.

Summary of Public Comments and Agency Responses:

The Board of Dentistry received four comments from interested parties during the official 30 day comment period.

Comments were received from the New Jersey Dental Association; John M. Pellecchia, Esq. (Riker, Danzig, Scherer, Hyland and Perretti) on behalf of the New Jersey State Association of Endodontists, New Jersey Society of Oral and Maxillofacial Surgeons, New Jersey Association of Orthodontists, New Jersey Academy of Pediatric Dentistry, New Jersey Society of Periodontists, and American College of Prosthodontists; John Paul Dizzia, Esq.; and New Jersey Association of Orthodontists. A summary of the comments received and the Board's responses follows.

COMMENT: N.J.A.C. 13:30-8.6(c)2 permits claims that services or materials are professionally superior if such claims can be substantiated by the licensee. While a claim may be theoretically substantiated by objective facts, it may nevertheless be misleading or deceptive. In the event the Board is not persuaded to retain the current prohibition on claims of superiority, it is suggested that additional language reaffirm the Board's policy against deceptive advertising.

RESPONSE: A total prohibition on advertisements that contain claims of superiority unduly restricts comparative advertising which may contain truthful information about different products and services available in dental practices. In view of the fact that a licensee may be called upon to substantiate such claims, the patient's need to be protected from false and/or misleading advertising is minimized. However, the Board also agrees that language that stresses that professional advertising may not be misleading or deceptive is beneficial to everyone and has amended this section to include the over-riding requirement that such claims not be misleading or deceptive.

COMMENT: Testimonials in advertising should be prohibited completely. However, at the very least, such advertisements should be required to disclose whether or not the testimonial giver was paid any fee or compensated directly or indirectly in exchange for the testimonial.

RESPONSE: After further discussion the Board agrees that it should require an appropriate disclosure statement when a testimonial is utilized in advertising so that the consuming public will not be misled and will be able to use their own judgment in cases where testimonials have been paid for. Accordingly, the Board has not adopted the amendment at N.J.A.C. 13:30-8.6(m) but will repropose an amendment concerning testimonials with appropriate disclaimers.

COMMENT: N.J.A.C. 13:30-8.6(h) now would permit one licensee responsible for the dental practice in a facility to be identified in an advertisement rather than all of the principals in the practice as previously required. The current regulation requiring each principal licensee to be identified is an appropriate enforcement tool. This requirement may help reduce the frequency of misleading, deceptive or blatantly false advertisements.

RESPONSE: The growth in group practices in New Jersey with which large numbers of dentists are associated makes the requirement of identifying each principal in an advertisement unduly burdensome both in terms of costs and in space requirements. In some cases the disclosure of each principal would be highly impractical as in the case of broadcast advertising. The Board is satisfied that it can enforce the provisions of professional advertising so long as one licensee is identified in the advertisement as responsible for the public representations of that particular dental facility.

COMMENT: The "dignified" advertising standard should be maintained. It is no more ambiguous than other standards in other Board regulations.

RESPONSE: It has been the Board's experience that it is very difficult to apply the dignified standard. Concepts of what is humiliating or silly or absurd are highly personal. What one person may find undignified

may be perfectly acceptable to another individual. Accordingly, the Board has determined to consider proposing in the future an amendment to the regulation which would require that all advertisements be predominantly informational. However, for the present the Board is satisfied that the dignified standard is no longer appropriate.

COMMENT: Claims of professional superiority and testimonials will be very difficult to verify. These claims should be prohibited because of the extreme difficulty in assuring their accuracy.

RESPONSE: Outright prohibitions also have the effect of depriving potential patients of information which may be helpful to them in selecting a dentist. As a result, it appears to the Board that the restrictions imposed on claims of superiority which may result in a licensee being called upon to substantiate such claims will be a sufficient deterrent to those licensees who would consider engaging in misleading advertising.

COMMENT: The proposed amendments, as a whole, show that the Board is properly focusing its attention on the need for accurate public disclosure of professional services in advertising and that it is moving away from simply prohibiting professional advertising *per se*.

RESPONSE: Accepted.

Full text of the adoption follows (addition to proposal indicated in boldface with asterisks ***thus***).

13:30-8.6 Professional advertising

(a) (No change.)

(b) A licensed dentist who is actively engaged in the practice of dentistry in the State of New Jersey may provide information to the public by advertising in print or electronic media.

(c) A licensee who engages in the use of advertising which contains the following shall be deemed to be engaged in professional misconduct:

1. (No change.)

2. Claims that the service performed or the materials used are professionally superior to that which is ordinarily performed or used unless such claims can be substantiated by the licensee ***and are not misleading or deceptive***.

3.-9. (No change.)

(d) The Board may require a license to substantiate the truthfulness of any objective assertion or representation set forth in an advertisement. Failure of a licensee to provide factual substantiation to support a representation or assertion shall be deemed professional misconduct.

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

(h) All licensee advertisements and public representations shall contain the name and address or telephone number of the licensee, professional service corporation or trade name under which the practice is conducted and shall also set forth the names of at least one licensee responsible for the dental practice in the facility identified in the advertisement and/or public representation.

(i)-(l) (No change.)

TREASURY-GENERAL

(a)

DIVISION OF PENSIONS AND BENEFITS

State Health Benefits Commission

Coverage Changes

Adopted Amendment: N.J.A.C. 17:9-2.4

Proposed: April 19, 1993 at 25 N.J.R. 1671(b).

Adopted: June 11, 1993 by the State Health Benefits Commission, Patricia Chiacchio, Acting Secretary.

Filed: June 15, 1993 as R.1993 d.349, **with a technical change** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 52:14-17.27 et seq.

Effective Date: July 6, 1993.

Expiration Date: October 3, 1993.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows (addition to proposal indicated in boldface with asterisks ***thus***; deletion from proposal indicated in brackets with asterisks *[thus]*).

17:9-2.4 Coverage changes; exception

(a) An employee may change his or her enrollment and the enrollment of his or her dependents to any type of coverage at any time if such changes result from a change in family, dependency or employment status of the employee or his or her dependents. Such changes will be permitted under the following conditions:

1.-8. (No change.)

[8.]**9.*** *Upon return to employment from an approved leave of absence.* The employee may elect to change coverage to add any eligible dependent(s) who had been removed from this group coverage while the employee was on such leave.

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

TREASURY-TAXATION

(b)

DIVISION OF TAXATION

Business Personal Property Tax

Readoption: N.J.A.C. 18:9

Proposed: April 5, 1993 at 25 N.J.R. 1485(b).

Adopted: June 3, 1993 by Leslie A. Thompson, Director, Division of Taxation.

Filed: June 4, 1993 as R.1993 d.312, **without change.**

Authority: N.J.S.A. 54:11A-19.

Effective Date: June 4, 1993.

Expiration Date: June 4, 1998.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 18:9.

(c)

DIVISION OF TAXATION

Sales and Use Tax

Readoption with Amendments: N.J.A.C. 18:24

Adopted Repeals: N.J.A.C. 18:24-2.13, 10.7, 11.3, 21, 24, 26.3, 28.6, and 29.3

Adopted Repeals and New Rules: 18:24-3.3 and 7.18

Proposed: April 5, 1993 at 25 N.J.R. 1486(a).

Adopted: June 3, 1993 by Leslie A. Thompson, Director, Division of Taxation.

Filed: June 4, 1993 as R.1993 d.313, **without change.**

Authority: N.J.S.A. 54:32B-24.

Effective Date: June 4, 1993, Readoption;
July 6, 1993, Amendments, Repeals and New Rules

Expiration Date: June 4, 1998.

Summary of Public Comments and Agency Responses:

The Division of Taxation received two public comments in response to the proposed readoption with amendments, one from Ms. Dianne Carey of AT&T and one from Mr. Dennis Brown of the Equipment Leasing Association of America. Both comments addressed the same issues with respect to the sales tax treatment of leasing transactions.

COMMENT: Both commenters stated that the rules dealing with leasing should express the Division's position that the sale of leased

property by a lessor upon lease termination is not a taxable transaction in a case where the lessor has paid the lease tax using the purchase price option. In addition, they suggested that the Division's treatment of lease assignments by and between various lessors are treated as nontaxable transactions and should be included in the rules.

RESPONSE: Although both of these changes would merely reflect the Division's past and current interpretation of the leasing law, P.L. 1989, c.123, neither one can be adopted as part of the current proposal, PRN 1993-176. The Administrative Procedure Act prevents an agency from including as part of an adoption substantive rule changes. These require the reproposal of the rule. Only changes of a minor nature can be included in an adoption if they do not destroy the value of the original notice and the public's opportunity for comment. The Division will consider making these changes a part of any future sales and use tax rule proposal.

Since the Division must readopt N.J.A.C. 18:24 to preclude expiration of the entire regulatory chapter, it is not possible at this time to amend PRN 1993-176 in the way proposed. Greater leasing law detail will be considered for inclusion in a future sales and use tax rule proposal.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 18:24.

Full text of the adopted amendments and new rules follows.

18:24-1.1 Sales and Use Tax Act forms enumerated

(a) The following list reflects sales and use tax forms currently available for use under N.J.S.A. 54:32B-1 et seq.

REGISTRATION APPLICATIONS

REG-1 Application for Registration with Division of Taxation

***

SPECIALIZED USE FORMS

***

ST-40 Lessor's Certification

***

URBAN ENTERPRISE ZONE FORMS

***

UZ-4A/5A Exempt Qualified Business Permit/Exempt Purchase Permit

***

18:24-1.3 Magazine and periodical defined

(a) A "magazine" means a periodical publication which generally conforms to all the following indicia:

1.-2. (No change.)

3. A periodical contains a variety of articles or other information;

4.-6. (No change.)

(b) (No change.)

18:24-1.4 Receipt defined

(a) (No change.)

(b) Excise taxes which are imposed on manufacturers, importers, producers, distributors or vendors are included in the receipt on which sales or use tax is computed, even though the excise tax may be separately stated to the purchaser. Thus, the Federal manufacturer excise taxes imposed on the sale or lease of certain automobiles (gas guzzlers) are included in the taxable receipt as are the excise taxes on tires, sporting goods and firearms.

1. Excise taxes which are imposed on the consumer are excluded from the taxable receipt; for example, the Federal retail excise taxes on heavy trucks and trailers sold at retail and the Federal luxury tax on certain retail purchases.

(c)-(k) (No change.)

(l) Any charges for credit imposed by a vendor and paid by a purchaser in addition to the purchase price under a designation such as interest, service charge, or finance charge is not deemed to be part of the sales price of tangible personal property or charge for services rendered. Such charges are consideration for the extension of credit and shall not be included in the receipt subject to sales tax.

Example: A vendor sells furniture for $1,000 and charges 1½ percent interest per month on the outstanding balance. Only the $1,000 is a receipt subject to tax.

1. (No change.)

2. Interest paid by a lessor on the purchase of tangible personal property intended to be rented for 28 days or less to a customer is an expenditure of the lessor and is to be included in the receipt subject to tax.

Example: A taxpayer purchases equipment on credit for rental purposes. The agreement for 28 days or less provides that the party renting is to pay $100.00 per month for equipment rented and $7.00 per month to reimburse the lessor for interest paid. The tax is to be collected on $107.00.

(m)-(n) (No change.)

(o) Charges for the use or rental of tangible personal property for periods of 28 days or less are subject to tax based on the amount billed for the period of use. The lessor is required to collect and remit the tax on the receipts from the rental.

(p) The amount of the sales price of tangible personal property purchased for lease for a period of more than 28 days is subject to tax and means, at the election of the lessor, either:

1. The amount of the lessor's purchase price; or

2. The amount of the total of the lease payments attributable to the lease of such property. A lessor, as a retail purchaser, is required to pay the tax upon the purchase of property for lease.

Example 1: A leasing company purchases an automobile for $20,000. After the purchase the company enters into a three year lease agreement with a customer who will pay a total of $15,000 over this period. The lessor at the time the lease is executed must elect to pay tax on the purchase price of $20,000 or on the contract lease price of $15,000, less the interest charge to the lessee.

Example 2: A rental company purchases automobiles to be held for short term rentals of 28 days or less. In this case the sales tax is not imposed on the rental company; however, it must collect the applicable sales tax on each rental payment from a customer renting an automobile.

(q) The taxable receipt for intrastate and interstate telecommunications is the amount charged to a service address in New Jersey regardless of where the services are billed or paid.

18:24-2.3 General requirements

(a) A true copy of all sales slips, invoices, receipts, statements, memoranda of price, or cash register tapes, issued to any customer by a vendor who is required to be registered pursuant to the provisions of the Sales and Use Tax Act (N.J.S.A. 54:32B-1 et seq.) and records of every purchase and purchase for lease must be available for inspection and examination at any time upon demand by the Director, Division of Taxation, or his duly authorized agent or employee and shall be preserved for a period of three years from the filing date of the quarterly period for the filing of sales tax returns to which such records pertain.

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

18:24-3.3 Guest house

A boarding or rooming house containing fewer than eight units must be registered and collect and remit sales tax on taxable occupancies as a hotel unless it is held out by the operator and kept open for the residence of permanent boarders or lodgers. A permanent boarder or lodger is any person who occupies or has the right to occupy a room or rooms in the house for at least 90 consecutive days.

18:24-4.4 Purchase, rental, lease or use of machinery, apparatus or equipment directly in production exempt from tax

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

(g) The exemption will apply to industrial owners, mechanical contractors and their suppliers where an industrial owner awards a contract to a mechanical contractor to install manufacturing machinery, apparatus or equipment, to produce tangible personal property for sale, to be used by the owner upon completed construction and acceptance after January 1, 1978. The installation may be made in a new or existing industrial plant of the owner designed for or currently used for the manufacture of tangible personal property. For example:

1.-4. (No change.)

5. Under the above facts the rental of equipment or vehicles for use on the job of the mechanical contractor is not exempt from tax. A rental for 28 days or less is taxable to the contractor and tax is due on the rental charge. On leases for more than 28 days the tax is imposed on the purchase of property for lease and is paid by the lessor. (See N.J.A.C. 18:24-1.4(o)).

6.-9. (No change.)

18:24-4.6 Services subject to tax

(a) The following enumerated services, purchased or sold by any person engaged in manufacturing, processing, assembling or refining, as defined in section 2 of this subchapter, not purchased for resale, that is, not performed on property offered for sale by the purchaser, are subject to sales and use taxes, as well as services otherwise taxable:

1. (No change.)

2. Installing tangible personal property, except where such installation results in a capital improvement to real property. In determining whether an installation of tangible personal property results in a capital improvement to real property, the following factors should be considered:

i.-ii. (No change.)

iii. The treatment, for accounting purposes, of such improvements for Federal internal revenue purposes.

3. (No change.)

18:24-4.7 Services not subject to tax

(a) The following services are not subject to tax.

1. (No change.)

Recodify existing 3 and 4 as 2 and 3.

18:24-5.3 Purchase of materials and supplies by contractors

(a) (No change.)

(b) Except as hereinafter provided, contractors purchasing materials and supplies must pay the sales tax at the time of purchase. This subchapter does not apply where:

1. The purchase of materials and supplies is made for exclusive use in the fulfillment of a contract to improve or repair the real property of an exempt organization described in N.J.S.A. 54:32B-9(a) and 9(b) or a qualified business described in the New Jersey Urban Enterprise Zones Act, N.J.S.A. 52:27H-29, or a housing sponsor described in N.J.S.A. 54:32B-8.22(c).

i. (No change.)

Recodify ii as 2. (No change in text.)

18:24-5.4 Equipment purchase, rental or use

The purchase, rental for 28 days or less, or use of equipment by a contractor is subject to tax, whether or not the equipment is purchased, rented or used in fulfillment of a contract with an exempt organization. Lessors shall be taxed on lease transactions of more than 28 days duration. See N.J.A.C. 18:24-1.4(o).

18:24-5.6 Contractor's tangible personal property installation services

Services rendered by a contractor in installing tangible personal property, except in those instances where such services are rendered in connection with the installation of property which, when installed, will constitute an addition or capital improvement to real property are subject to tax.

18:24-5.8 Contractor services maintaining, servicing or repairing real property

(a) (No change.)

(b) The following maintenance, services, and repair operations are not subject to tax.

1. (No change.)

2. (No change in text.)

(c) (No change.)

18:24-5.16 Certificate issuance and acceptance procedures

(a) Procedures to be followed by contractors and fabricator/contractors with respect to the issuance and acceptance of certificate forms are as follows:

1. (No change in text.)

2. Exempt Use Certificates (Form ST-4) may be issued by contractors and fabricator/contractors only in cases where the materials purchased are for exclusive use in installing machinery, equipment or apparatus exempt at the time of purchase under the provisions of Section 8 of the Sales and Use Tax Act. In those instances where a valid Exempt Use Certificate may be issued by a contractor or fabricator/contractor, the certificate form must disclose his business name, sales tax registration number, the name and sales tax registration number of any other party to the contract, the nature of the work to be performed, and the date the work will commence.

Recodify existing (c)-(e) as 3.-5. (No change in text.)

6. Certificates of Capital Improvement (Form ST-8) should be obtained by a contractor, subcontractor or fabricator/contractor from his customer in any instance where the performance of his work results in a capital improvement to real property. A contractor or a fabricator/contractor may accept certificates of capital improvement as a basis for exemption from tax on his services only where his work has, in fact, resulted in a capital improvement to real property. The nature of the work performed is the determining factor in deciding whether to collect tax on a contractor's services. The possession of a certificate of capital improvement, in and of itself, is not sufficient to eliminate liability for taxes which should have been collected. The contractor must accept such certificate in "good faith" to be relieved of liability.

i. "Capital improvement" means an installation of tangible personal property which results in an increase of the capital value of the real property or a significant increase in the useful life of such property. See N.J.A.C. 18:24-5.7.

Recodify existing 2.-5. as ii.-v. (No change in text.)

vi. The use of the Certificate of Capital Improvement, form ST-8, is required in all applicable transactions.

7. Contractor's Exempt Purchase Certificate (Form ST-13).

i. (No change in text.)

8. An Exempt Qualified Business Permit/Exempt Purchase Permit (Form UZ-4A/5A) must be completed by the contractor when the contractor purchases materials or supplies exclusively for performing work for a qualified business at the business's real property located in an urban enterprise zone. The UZ-4 is obtainable only from the qualified business. After completing the UZ-4, the contractor must issue copies to its vendors and its subcontractors. Any subcontractor receiving a UZ-4 must attach its name, address, and Certificate of Authority number (in addition to the name, address, and number of the contractor) and then give the UZ-4 and attachments to its vendors. "Qualified business" means a person or entity that the Urban Enterprise Zone Authority has certified to be a qualified business according to the criteria in N.J.S.A. 52:27H-62c.

9. If a qualified housing sponsor, as defined in N.J.S.A. 55:14K-3 of the New Jersey Housing and Mortgage Finance Agency Law of 1983, has received Federal, State or local government subsidies, as verified by the New Jersey Housing and Mortgage Finance Agency on a Certification of Housing Sponsor form, in addition to New Jersey Housing and Mortgage Finance Agency financing for the specific housing project, contractors of the housing sponsor, pursuant to P.L. 1988, c.83, may purchase materials, supplies and services tax free for the specific housing project. The contractor must receive a copy of the housing sponsor's Letter of Exemption for his records and may then issue a Contractor's Exempt Purchase Certificate (Form ST-13) to his suppliers to document his exempt purchases for the housing project.

18:24-6.1 Clothing and footwear exempt

Section 8.4 of the New Jersey Sales and Use Tax Act, N.J.S.A. 54:32B-1 et seq., exempts receipts from the sale of articles of clothing and footwear for human use except articles made of fur on the hide or pelt of an animal, where such fur is the component material or chief value of the article.

18:24-6.2 Clothing and footwear defined

For the purposes of Section 8.4 (see N.J.A.C. 19:24-6.1), clothing and footwear means all inner and outer wear, footwear, headwear, gloves and mittens, neckwear and hosiery customarily worn on the human body, and shall include baby blankets and bunting, diapers

and diaper inserts and baby pants. For the purpose of section 8.4 special clothing or safety clothing necessary for the daily work of the user shall be considered clothing and footwear.

18:24-6.3 Specific articles of clothing and footwear exempt

(a) The following articles of clothing and footwear are deemed exempt from the sales and use tax under N.J.S.A. 54:32B-8.4 and N.J.S.A. 54:32B-24:

1.-40. (No change.)

18:24-6.4 Clothing and footwear for sporting activities

Clothing and footwear used in connection with sporting activities or pastimes, which clothing and footwear are not adaptable to a use set forth in N.J.A.C. 18:24-6.2 (Clothing and footwear defined) shall not be considered to be clothing and footwear within the meaning of Section 8.4 of the Act.

18:24-6.5 Athletic goods and equipment

(a) Athletic equipment normally worn only in conjunction with the particular activity for which it is designed is subject to the sales tax. This includes, but is not limited to:

1.-8. (No change.)

9. Track shoes and cleats;

10. Motorcycle helmets; and

11. Ski boots.

(b) (No change.)

18:24-6.6 Fur garments and articles

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

(d) The sale of remodeling services for fur garments and articles is subject to sales tax.

18:24-7.3 Tax payment prerequisite to registration

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

(c) If the motor vehicle is not required to be registered with the Division of Motor Vehicles, the vendor thereof must collect the tax from the purchaser, if any such tax is due, and must remit the same to the Division of Taxation.

18:24-7.4 Computation of tax on purchase price; trade-in

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

(c) A deduction from the purchase price, equal in amount to the amount of a trade-in actually allowed on the purchase, will be permitted; provided, that:

1.-2. (No change.)

3. The trade-in is acquired by a dealer of motor vehicles who is registered as such with the Division of Motor Vehicles and the New Jersey Division of Taxation.

18:24-7.8 Sales of motor vehicles specifically exempted

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

(c) Any sale of a motor vehicle to be used exclusively for rental for a period of 28 days or less is purchased for resale and is not subject to tax at the time of purchase.

(d) The renting, leasing, licensing or interchanging of trucks, tractors, trailers, or semitrailers by persons not engaged in a regular trade or business offering such renting, leasing, licensing or interchanging to the public; provided, however, that such renting, leasing or interchanging is carried on with persons engaged in a regular trade or business involving carriage of freight by such vehicles is exempt from tax.

(e) For purposes of subsection (d) of this section, "carriage of freight" means property transported by a common or public carrier, such as regular trucking companies, and does not include the type of business utilizing rented or leased vehicles to transport its own goods. For example, a vendor of welding supplies leases trucks from a person not engaged in the regular trade or business of leasing such vehicles to the public. The trucks are used to transport to the vendor's customers its own goods. The exemption from tax does not apply since the vendor is not engaged in the carriage of freight, unless the trucks qualify for exemption under subsection 8.43 of the Sales and Use Tax Act (see N.J.A.C. 18:24-7.18).

18:24-7.10 Procedures for motor vehicle dealers; forms and certificates

(a) New Jersey motor vehicle dealers are required to execute and retain as a part of their records Form ST-10 if a purchaser of a motor vehicle:

1.-5. (No change.)

6. The sale of a warranty in conjunction with the sale of a motor vehicle qualified for exemption under this subsection is not subject to sales tax.

(b) A Resale Certificate may be accepted by a dealer of motor vehicles in cases of sales to other licensed dealers where the vehicle is purchased for resale, or is being acquired for rental purposes. A Resale Certificate may be accepted from a lessor registered for sales tax purposes in New Jersey. In all such cases, the purchaser's Certificate of Authority number and name and address must be shown on each sales invoice. The certificate itself should be retained in the dealer's files.

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

18:24-7.11 Casual sales of motor vehicles

Under the provisions of N.J.S.A. 54:32B-3(a) and N.J.S.A. 54:32B-8.6, casual sales (as defined in N.J.S.A. 54:32B-2(u)) of motor vehicles, unless otherwise exempted, are subject to tax.

18:24-7.12 Taxable and exempt services

(a) The following services, except as hereinafter provided, sold or purchased by a dealer in motor vehicles, are subject to tax; provided, however, that where the following services are performed on tangible personal property held for sale by the purchaser of such services, the performance of such services is not subject to tax:

1. Installing, maintaining, servicing, or repairing tangible personal property; where such services are sold by a dealer or motor vehicles, or any other person engaged in the performance of such services;

2.-3. (No change.)

(b)-(f) (No change.)

18:24-7.13 Taxability of motor vehicles used by manufacturer before sale; computation

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

(d) In computing the tax, the basis for tax as computed in (c) above shall be multiplied by .06 to effectuate the six percent tax imposed pursuant to N.J.S.A. 54:32B-6.

18:24-7.15 Renting motor vehicles

(a) The total charge for the rental for 28 days or less of a motor vehicle to the customer is subject to the six percent New Jersey sales and use tax pursuant to N.J.S.A. 54:32B-3(a), except as set forth in (b) above.

(b) (No change.)

18:24-7.18 Sales, renting or leasing of commercial motor vehicles and vehicles used in combination therewith exempt from tax

(a) Receipts from sales of the following are exempted from the tax imposed under the Sales and Use Tax Act:

1. Sales, renting or leasing of commercial trucks, truck tractors, tractors, trailers, semitrailers, and vehicles used in combination therewith, as defined in N.J.S.A. 39:1-1, which are registered in New Jersey, and:

i. Have a gross vehicle weight rating in excess of 26,000 pounds; or

ii. Are operated actively and exclusively for the carriage of interstate freight pursuant to a certificate or permit issued by the Interstate Commerce Commission; or

iii. Are registered pursuant to N.J.S.A. 39:3-24 or N.J.S.A. 39:3-25 and have a gross vehicle weight rating in excess of 18,000 pounds.

2. Repair parts and replacement parts for such vehicles. Parts shall not include lubricants, motor oil or antifreeze.

(b) For the purposes of this section, "gross vehicle weight rating" means the value specified by the manufacturer as the loaded weight of the single or combination vehicle and, if the manufacturer has not specified a value for a towed vehicle, means the value specified for the towing vehicle plus the loaded weight of the towed unit.

(c) For the purposes of this section, "truck" means every motor vehicle designed, used, or maintained primarily for the transportation of property.

(d) For the purposes of this section, "truck tractor" means every motor vehicle designed and used primarily for drawing other vehicles and not so constructed as to carry a load other than a part of the weight of the vehicle and load so drawn.

(e) For the purposes of this section, "trailer" means every vehicle with or without motive power, other than a pole trailer, designed for carrying persons or property and for being drawn by a motor vehicle and so constructed that no part of its weight rests upon the towing vehicle.

(f) For the purposes of this section, "semitrailer" means every vehicle with or without motive power, other than a pole trailer, designed for carrying persons or property and for being drawn by a motor vehicle and so constructed that some part of its weight and that of its load rests upon or is carried by another vehicle.

(g) For the purposes of this section, "vehicle used in combination therewith" means and includes motor-drawn vehicles, such as trailers, semitrailers, or pole trailers.

(h) For the purpose of motor vehicle dealer records indicating why sales tax has not been collected on sales of motor vehicles exempt from tax under this section or repair parts and replacement parts therefor, the dealer is required to receive a properly completed Exempt Use Certificate (Form ST-4) from the purchaser whether such purchaser is or is not registered with the Division of Taxation. When the purchaser is not registered with the Division of Taxation, a Certificate of Authority number is not required. However, an Interstate Commerce Commission identification number or New Jersey registration plate number must be shown on Form ST-4.

(i) Nonconventional type motor vehicles not designated or used primarily for the transportation of property and only incidentally operated or moved over a highway, such as ditch digging apparatus, well-boring apparatus, road and general purpose construction and maintenance machinery, asphalt, spreaders, bituminous mixers, bucket loaders, ditchers, leveling graders, road rollers, earth-moving carryalls, self-propelled cranes, earth-moving equipment, bulldozers, road building machinery, and so forth, vehicles which operate on general registration plates transferable from vehicle to vehicle and which identify the owner rather than the vehicle, are not exempt from sales tax.

(j) Equipment mounted on vehicles exempt from tax under this section is eligible for exemption only if it is an integral part of the basic vehicle, and the basic vehicle would lose its identity should the equipment be removed. If the equipment is not an integral part of the vehicle and can be severed from the vehicle, the equipment is not exempt from tax.

Example 1: Motor vehicle bodies or bodies on vehicles used in combination with exempt vehicles, such as trailers or semitrailers, permanently mounted so that they effectuate the purpose for which the vehicle is intended are exempt from tax.

Example 2: Devices used in or on vehicles for effectuating business purposes, such as shortwave receiving and transmitting of messages, are not considered an integral part of such vehicle and are not exempt from tax.

18:24-7.19 Taxation of manufactured and mobile homes

(a) This section is intended to clarify the taxation of manufactured or mobile homes under the provisions of P.L. 1983, c.400, approved December 22, 1983. This section does not apply to the sale of modular buildings because they are not on a permanent chassis.

1. (No change.)

(b)-(h) (No change.)

18:24-8.2 Exemption not based on nonprofit status

An organizaton is not exempt from tax merely because it is a nonprofit organization. In order to establish this exemption, it is necessary that every organization claiming exemption file with the Division of Taxation an application form ST-5B.

18:24-8.4 Application for exemption; information

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

(c) To each application should be attached:

1.-4. (No change.)

5. A copy of the organization's Federal tax determination letter or ruling issued by the Internal Revenue Service.

(d) (No change.)

18:24-9.3 Organizational tests

(a) In general:

1.-5. (No change.)

6. An organization should submit a copy of its Section 501(c)(3) determination letter or ruling issued by the Internal Revenue Service as prima facie evidence of exemption under Section 9(b)(1) of the Sales and Use Tax Act. A Federal exemption granted under Section 501(c)(4) or another section of the Internal Revenue Code is not a basis for exemption under the Sales and Use Tax Act.

(b)-(e) (No change.)

18:24-9.12 Sales of meals and rental of rooms to exempt organizations

(a) Receipts from the sale to exempt organizations of food and drink in or by restaurants, taverns or other establishments in this State, or by caterers, including in the amount of such receipts any cover, minimum entertainment or other charge made to patrons or customers, and rental of rooms to exempt organizations in a hotel shall be treated in the following manner:

1. Whenever there is such a sale of food or drink, the vendor shall charge and collect the sales tax thereon unless an organization holding a valid exempt organization permit (Form ST-5A) furnishes the vendor with a valid properly executed exempt organization certificate (Form ST-5) which has the name, address and registration number of the exempt organization imprinted on the certificates by the Division of Taxation along with the signature of the director;

2. Whenever there is a room occupancy, the hotel shall charge and collect the sales tax thereon unless an organization holding a valid exempt organization permit (Form ST-5A) furnishes the vendor with a valid properly executed exempt organization certificate (Form ST-5) which has the name, address and registration number of the exempt organization imprinted on the certificate by the Division of Taxation along with the signature of the director;

3. In all cases, the exempt organization must pay the bill with organizational funds and the organization must hold a valid exempt organization permit (Form ST-5A) as of the date of the transaction;

4. Any organization holding a valid exempt organization permit (Form ST-5A), which has paid the sales tax in accordance with the foregoing procedure, may apply to the New Jersey Division of Taxation for a refund of the tax if all the charges on which the tax was calculated were paid by the organization using organizational funds.

18:24-12.1 Scope of subchapter

This subchapter will clarify the application of the New Jersey Sales and Use Tax Act (N.J.S.A. 54:32B-1 et seq.) to the sale of food and drink in or by restaurants, taverns or other establishments and caterers.

18:24-12.3 Receipts subject to tax

(a) Sales tax is imposed on the receipts, including any cover, minimum, entertainment or other charge, or the value of a coupon, from every sale of food and drink of any nature sold in or by restaurants, taverns or other establishments in this State or by caterers:

1.-2. (No change.)

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

18:24-12.5 Receipts exempt from sales tax

(a) The tax imposed on the sale of food and drink shall not apply to the following:

Recodify existing 2. through 6. as 1. through 5. (No change in text.)

6. Food and drink furnished by an employer to employees for the employee's convenience where assigned a money value for purposes of: inclusion in remuneration, which is the basis for computing the employers' contribution to the unemployment insurance

fund; social security; or meeting minimum wage requirements (regarding employees of hotels and restaurants). To qualify for exemption, no cash may change hands as payment for the food and drink and the assigned value of such food and drink cannot be classified as income for Federal or New Jersey income tax purposes.

7. (No change in text.)

(b) (No change.)

18:24-13.2 Trash removal service defined

(a) (No change.)

(b) Removal includes only the operation of picking up and physically removing contained waste from the premises and does not include activities related to maintaining or servicing property or any processing of the waste product. Removal would, therefore, not include sweeping parking lots, snow removal and construction site clean-up, or a process such as septic tank cleaning.

(c) (No change.)

SUBCHAPTER 14. TAXABILITY OF HOSPITAL SALES AND SERVICES

18:24-14.2 Modification by hospital sales exemption for retail sales

(a) The exemption provided in N.J.A.C. 18:24-14.1 is modified by N.J.S.A. 54:32B-9(c) which provides in part that the retail sales of tangible personal property by any shop or store operated by such organization shall be subject to the tax unless the purchaser is an exempt organization.

(b) (No change.)

SUBCHAPTER 15. TAXABILITY OF CERTAIN LINEN RENTALS

18:24-15.3 Tax computation; inclusion on invoice

(a) The tax must be calculated at the rate of six percent on the adjusted charge as set forth in N.J.A.C. 18:24-15.2.

(b) The invoice given to the customer must show the total charge prior to the reduction, the percentage reduction and the net total charge subject to the sales tax. It must also contain a calculation showing a multiplication by .06 times the net charge to effectuate the imposition of the six percent tax due.

18:24-15.4 Improper indication of tax rate

It is improper for a vendor of linen furnishings to indicate that the effective rate of tax is two percent of the total charge.

18:24-16.6 Tax on gross receipts

(a) Vendors operating vending machines which dispense tangible personal property, other than food and drink, must report and pay to the State the tax upon the gross receipts from all sales of such items made through such machines, subject to the exemptions set forth in the Sales and Use Tax Act such as items sold through vending machines for $0.10 or less (exempt under N.J.S.A. 54:32B-8.9 and N.J.A.C. 18:24-17).

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

(e) Example:

. . .

Tax due (at 6 percent) $396

18:24-16.9 Responsibility for tax payment; amount

(a) (No change.)

(b) The tax to be remitted to the State of New Jersey by the vendor is the amount of the actual tax collected from all taxable sales, or six percent of the taxable sales, whichever amount is greater.

18:24-17.4 Tax amount payable

The amount of New Jersey sales tax payable is the net taxable receipts multiplied by .06 to effectuate application of the six percent tax rate, or the actual tax collected, whichever is the greater.

SUBCHAPTER 18. TAXABILITY OF MOTOR FUELS

18:24-18.1 Motor fuel exempt from Act

(a) N.J.S.A. 54:32B-8.8 exempts sales of motor fuels as motor fuels are defined for the purposes of the New Jersey Motor Fuels Tax Law and sales of fuel to an airline for use in its airplanes or to a railroad for use in its locomotives.

(b) In accordance with (a) above sales of fuels used to propel any aircraft or motor vessel are exempt from the New Jersey sales and use tax.

18:24-19.1 Scope of rule

This section is intended to clarify the application of the Sales and Use Tax Act (N.J.S.A. 54:32B-1 et seq.) to sale, rental or leasing of tangible personal property used directly and exclusively in the production for sale of tangible personal property on farms. (N.J.S.A. 54:32B-8.16).

18:24-19.3 Exemption

(a) The exemption provided by N.J.S.A. 54:32B-8.16 applies to the purchases of tangible personal property.

(b) There is no exemption for the purchase of taxable services.

18:24-19.4 Directly in production

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

(c) Production machinery, equipment, implements and other articles have exempt status when used exclusively in the growing, stimulation of growth processing of tangible personal property on farms to a marketable state.

1. (No change.)

2. The purchase or use of tangible personal property by a person engaged in the business of farming is exempt from tax if such property is exclusively used by him directly in farming operations. However, purchases of automobiles, trucks, trailers and truck-trailer combinations as well as supplies and repair parts for such vehicles are subject to tax; provided, however, that certain trucks, trailers and truck-trailer combinations are exempt from tax in accordance with N.J.S.A. 54:32B-8.43. (See N.J.A.C. 18:24-7.18.)

(d)-(h) (No change.)

18:24-19.6 Taxable and exempt items

Schedules A and B show examples of items of tangible personal property taxable and exempt under N.J.S.A. 54:32B-8.16.

EXEMPT SALES—(SCHEDULE "A") (No change.)

TAXABLE SALES—(SCHEDULE "B") (No change.)

18:24-23.2 Bad debts; tax refund

(a) Where the sales tax in connection with a sale has been remitted to the Division of Taxation and the account receivable has proven to be worthless and uncollectible, and application for a refund may be filed with the Director within two years from the payment thereof:

1.-3. (No change.)

4. The following example illustrates the foregoing rules:

If the sale amounted to $500.00 and the sales tax of $30.00 was paid over to the Division by the vendor and the total collected by the vendor amounted to $50.00, no refund would be allowed since the amount paid to the Division did not exceed the amount collected by the vendor from his customer. If, however, in the given example, the vendor collected only $15.00 from the customer, he would be entitled to a $15.00 refund because the amount collected by the vendor was less than the amount paid to the Division. If the vendor collected no money, he would be entitled to a refund of $30.00. This assumes, of course, that the debt is proven to the satisfaction of the Division to be worthless and uncollectible.

18:24-26.2 Technical sufficiency standards of solar energy systems; devices for storing solar-generated energy

The technical sufficiency standards of solar energy systems, devices for storing solar-generated energy as established and promulgated under N.J.A.C. 14.25 by the Department of Environmental Protection and Energy shall be used to determine eligibility for exemption from sales and use tax of such solar energy systems.

18:24-26.5 Nonexempt purchases

The exemption from tax will not apply to those devices or systems for heating or cooling, electrical or mechanical power that would be required regardless of the energy source being utilized.

18:24-28.2 Purchase of race horses

(a) (No change.)

(b) The amount of the sales tax due is computed by multiplying the purchase price of the race horse by six percent.

(c) The residency of the purchaser is not considered for purposes of imposing the tax where delivery is made to the purchaser in this State.

Example 1: A person purchases a race horse at an auction sale in Colts Neck. The purchase price of the horse is $15,000. The purchaser or his agent takes delivery of the horse at the sale in Colts Neck. The sales tax due on the transaction is $900.00.

Example 2. (No change.)

18:24-28.3 Claiming races

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

(c) For the purpose of computing the sales tax due, the purchase price of the claimed horse is the amount paid for the claim. The sales tax is collected at the track at the time the claim is paid.

Example 1: Horse X is entered in a $10,000 claiming race at Monmouth Park. ABC Farms claims the horse. A Taxable transaction has taken place and the tax due is $600.00.

18:24-28.4 Compensating use tax

(a) (No change.)

(b) The amount of the compensating use tax due is computed by multiplying the purchase price of the race horse by six percent. If such horse was used outside of this State for more than six months prior to its first use in this State, the compensating use tax is computed on the fair market value (not to exceed cost) of the race horse. Upon submission of proof that sales tax legally due another state has been paid to that state, New Jersey will allow a credit in that amount against any taxes due this State; but only if a similar credit is allowed by the other state for taxes paid in New Jersey.

SUBCHAPTER 29. DISPOSABLE HOUSEHOLD PAPER PRODUCTS: EXEMPTION FROM SALES AND USE TAX

18:24-29.1 Scope of subchapter

This subchapter is intended to clarify the application of the Sales and Use Tax Act (N.J.S.A. 54:32B-1, et seq.) to the purchase and use of disposable household paper products.

18:24-29.2 Definitions

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

. . .

18:24-29.4 Household paper products

The sale of disposable paper products, such as paper towels, paper napkins, toilet tissue, facial tissue, diapers, paper plates and cups, purchase for household use is exempt from sales and use tax.

Example: The sale of paper place mats, paper bags, wax paper, paper freezer wrap, paper tablecloths and paper straws is exempt from sales and use tax.

18:24-29.5 Business use

The exemptions from sales and use tax provided by this subchapter do not apply to the sale or any use of disposable paper products for industrial, commercial or other business purposes or for the use of any person consuming them in a capacity related to such purposes.

SUBCHAPTER 31. URBAN ENTERPRISE ZONES ACT

18:24-31.1 General

(a) The New Jersey Urban Enterprise Zones Act, Chapter 303, Laws of 1983, N.J.S.A. 52:27H-60, et seq., approved August 15, 1983, provides for the establishment of urban enterprise zones in urban areas suffering from high unemployment and economic distress. Each designation shall be for 20 years, and the right to establish enterprise zones shall expire 10 years from August 15, 1983. Zones are designated by an Urban Enterprise Zone Authority. The Authority may grant certain sales tax and other tax benefits to businesses existing in or formed in enterprise zones, which have met the definition of a qualified business. This subchapter of the sales tax rules sets forth the possible benefits, the necessary definition, and the procedures for qualifying for any of these sales tax benefits.

(b) (No change.)

(c) No business can obtain tax benefits under this subchapter unless the Urban Enterprise Zone Authority has determined that the business meets the definition of a qualified business under N.J.S.A. 52:27H-62c paraphrased below in N.J.A.C. 18:24-31.2.

18:24-31.2 Definitions

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

"Qualified business" means:

1. (No change.)

2. An entity which, after that designation but during the designation period of 20 years, becomes newly engaged in the active conduct of a trade or business within that zone, and has at least 25 percent of its full-time employees employed at a business location in the zone, who meet at least one of the following criteria:

i. Residents within the zone, within another zone or within the municipality within which the zone or any other zone is located; or

ii. Either unemployed for at least one year prior to being hired and residing in New Jersey, or recipients of New Jersey public assistance program, for at least one year prior to being hired; or

iii. Found to be economically disadvantaged, pursuant to the Jobs Training Partnership Act, P.L. 97-300 (29 U.S.C. 1501, et seq.).

. . .

18:24-31.3 Exemption for retail sales to a qualified business

(a) Retail sales and leases of tangible personal property (except motor vehicles) to a qualified business and sales of services (except telecommunications) to a qualified business for the exclusive use or consumption of such business within an enterprise zone are exempt from the sales and use taxes imposed by N.J.S.A. 54:32B-1, et seq., provided that the designation of the enterprise zone by the Urban Enterprise Zone Authority specifically makes this exemption available to the qualified business.

(b) (No change.)

(c) Qualified businesses purchasing or leasing tangible personal property (except motor vehicles) or services (except telecommunications services) to be used or consumed exclusively within the enterprise zone shall furnish to their vendors, suppliers or lessors a properly completed UZ-5, Urban Enterprise Exempt Purchase Certificate.

18:24-31.4 Partial exemption for retail sales of tangible personal property by a certified vendor

(a) Sales tax is imposed at 50 percent of the statutory rate, on receipts from retail sales, with exceptions stated in (b) or (c) below, made by a certified vendor which is a qualified business from a place of business owned or leased, and regularly operated by the vendor for the purpose of making retail sales, and located in a designated enterprise zone.

(b) This partial exemption does not extend to sales of motor vehicles, cigarettes, or alcoholic beverages.

(c)-(e) (No change.)

(f) Vendors that meet the requirements in (a) and (b) above and that lease tangible personal property may pay use tax at 50 percent of the regular rate, as long as the lease meets the requirements above. However, if the lessor later leases the property to a lessee that fails to meet the requirements in (e) above of completing the lease transaction at the lessor's place of business, tax shall be due at the regular rate, unless the lessee is exempt under some other exemption provided by the Sales and Use Tax Act.

18:24-31.5 No partial exemption for retail sales of taxable services by a qualifying business

The Urban Enterprise Zones Act in Section 21 provides for an exemption to the extent of 50 percent of the statutory rate of sales and use tax on retail sales, other than motor vehicles, cigarettes,

alcoholic beverages, and manufacturing machinery, equipment or apparatus, by a certified vendor which is a qualified business. The statute does not provide for any full or partial exemption on the sale or furnishing of taxable services.

(a)

DIVISION OF TAXATION

Transfer Inheritance and Estate Tax

Readoption: N.J.A.C. 18:26

Proposed: April 5, 1993 at 25 N.J.R. 1498(a).
Adopted: June 3, 1993 by Leslie A. Thompson, Director, Division of Taxation.
Filed: June 4, 1993 as R.1993 d.314, **without change.**

Authority: N.J.S.A. 54:50-1.

Effective Date: June 4, 1993.
Expiration Date: June 4, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 18:26.

(b)

DIVISION OF TAXATION

Gross Income Tax

Setoff of Individual Liability

Readoption: N.J.A.C. 18:35

Proposed: April 5, 1993 at 25 N.J.R. 1500(a).
Adopted: June 3, 1993 by Leslie A. Thompson, Director, Division of Taxation.
Filed: June 4, 1993 as R.1993 d.315, **without change.**

Authority: N.J.S.A. 54A:9-8.1 through 54A:9-8.3, 54A:9-17(a) and 54:50-1.

Effective Date: June 4, 1993.
Expiration Date: June 4, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 18:35.

OTHER AGENCIES

(c)

NEW JERSEY TURNPIKE AUTHORITY

Limitations On Use Of Turnpike

Adopted Amendment: N.J.A.C. 19:9-1.9

Proposed: February 16, 1993 at 25 N.J.R. 684(a).
Adopted: April 19, 1993 by the New Jersey Turnpike Authority, Herbert I. Olarsch, Director of Law, Administrative Procedures Officer.
Filed: June 3, 1993 as R.1993 d.311, **without change.**

Authority: N.J.S.A. 27:23-6.1 et seq.

Effective Date: July 6, 1993.
Expiration Date: October 17, 1993.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

19:9-1.9 Limitations on use of turnpike

(a) Use of the New Jersey Turnpike and entry thereon by the following is prohibited:

1.-11. (No change.)

12. Vehicles or combinations of vehicles, including any load thereon, exceeding the following extreme overall dimensions or weights:

i.-v. (No change.)

13.-25. (No change.)

(b) (No change.)

1. (No change.)

(d)

NEW JERSEY TURNPIKE AUTHORITY

Procedure for Prequalifications and Award of Construction Contracts

Adopted Amendment: N.J.A.C. 19:9-2.7

Proposed: January 4, 1993 at 25 N.J.R. 62(b).
Adopted: June 8, 1993 by New Jersey Turnpike Authority, Herbert I. Olarsch, Administrative Procedures Officer and Director of Law.
Filed: June 10, 1993 as R.1993 d.326, **without change.**

Authority: N.J.S.A. 27:23-6.1.

Effective Date: July 6, 1993.
Expiration Date: October 17, 1993.

Summary of Public Comments and Agency Responses:

The proposed amendment was published on January 4, 1993. During the comment period which closed February 3, 1993, two comments were submitted by contractors' associations.

COMMENT: Both commenters suggested that the proposal be amended to provide that if the bidder is allowed to withdraw its bid because of unilateral mistake, that bidder "shall" be disqualified from submitting a new bid on that project upon readvertisement. (National Electrical Contractors Association and Utility and Transportation Contractors Association of New Jersey).

RESPONSE: The Authority disagrees with the commenters' proposal. Such language could operate to deprive the Authority of significant savings, notwithstanding that a low bidder has made an excusable mistake and that there is no indication of improper behavior by the bidder. Such a rule would reduce the flexibility needed by the Authority to undertake contracts in a timely and economical manner and which is commonly exercised by most other state contracting agencies. The proposal would likely cost the public, bondholders and the Authority money by requiring the acceptance of a higher bid at no material gain to the integrity of the bidding process. Of course, any indication of improper conduct by the low bidder would continue to be a basis for disqualifying that bidder from bidding on the readvertised project or future contracts.

COMMENT: One commenter supported the Authority's amendment, and requested that it be amended to provide that if the putative low bidder submits an unresponsive bid or withdraws its bid due to unilateral mistake, the Authority "intends" to award the project to the next lowest responsive bidder if the second low bid is within the approximate range of the engineer's estimate for the project, subject to the Authority's right to readvertise the project for bid. (Utility and Transportation Contractors Association of New Jersey).

RESPONSE: The commenter's recommendation cannot be accepted because it would create more problems than it would solve. A statement of the Authority's intent to award to the second low bidder if the second low bid is close to the engineer's estimate would not bind the Authority inasmuch as the commenter's recommendation would also permit the Authority to readvertise the contract anyway. The commenter's proposal would also leave the Authority without a standard to determine how far from the engineer's estimate the second low bid would have to be to justify readvertisement, and would leave unclear whether the Authority could reject the second low bid even if it were very close to the engineer's estimate.

Full text of the adoption follows.

19:9-2.7 Procedure for prequalifications and award of construction contracts

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

(g) A bidder may be disqualified from future bidding on any Turnpike project if such bidder claims, whether successfully or not, its right to withdraw its bid because of a unilateral mistake. Such disqualification shall be effective for a period of six months from the date of opening the bid sought to be withdrawn. Only in cases where the withdrawing bidder did not act in a commercially reasonable manner would the Authority choose to disqualify the bidder.

(h) (No change.)

(a)

PUBLIC EMPLOYMENT RELATIONS COMMISSION

Appeal Board Rules

Readoption with Amendment: N.J.A.C. 19:17

Proposed: May 3, 1993 at 25 N.J.R. 1842(b).
Adopted: June 7, 1993 by the Public Employment Relations Commission, James W. Mastriani, Chairman.
Filed: June 7, 1993 as R.1993 d.322, **without change.**

Authority: N.J.S.A. 34:13A-5.9.

Effective Date: June 7, 1993, Readoption;
July 6, 1993, Amendment.
Expiration Date: June 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 19:17.

Full text of the adopted amendment follows.

19:17-3.3 Annual notice to nonmembers; copy of demand and return system to public employer

(a) Prior to the commencement of payroll deductions of the representation fee in lieu of dues for any dues year, the majority representative shall provide all persons subject to the fee with an adequate explanation of the basis of the fee, which shall include:

1. A statement, verified by an independent auditor or by some other suitable method of the expenditures of the majority representative for its most recently completed fiscal year. The statement shall set forth the major categories of expenditures and shall also identify expenditures of the majority representative and its affiliates which are in aid of activities or causes of a partisan political or ideological nature only incidentally related to the terms and conditions of employment or applied toward the cost of benefits only available to members of the majority representative.

2.-4. (No change.)

(b) (No change.)

(b)

CASINO CONTROL COMMISSION

General Provisions

Professional Practice

The Practice of Law

Adopted Amendment: N.J.A.C. 19:40-5.2

Proposed: April 19, 1993 at 25 N.J.R. 1672(a).
Adopted: June 3, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: June 7, 1993 as R.1993 d.316, **without change.**

Authority: N.J.S.A. 5:12-63c, 69a and 70k.

Effective Date: July 6, 1993.
Expiration Date: August 24, 1994.

Summary of Public Comments and Agency Responses:
One comment was received from the Sands Hotel & Casino ("the Sands").

COMMENT: The Sands stated that it takes no position concerning the proposal.

RESPONSE: Accepted.

Full text of the adoption follows.

19:40-5.2 The practice of law

(a) (No change.)

(b) Notwithstanding (a) above, an attorney admitted in this State who is in good standing but who does not maintain in this State a bona fide office for the practice of law, or an attorney of any other jurisdiction who is in good standing there, may in the discretion of the Chair be admitted to practice in connection with a particular matter by complying with the requirements of N.J.A.C. 1:1-5.2 and provided that an attorney authorized to practice law in this State who is in good standing shall also appear of record in and thereby be responsible for the conduct of the admitted attorney in the particular matter and that both such attorneys shall sign all papers submitted or filed in accordance with the regulations of the Commission.

(c)

CASINO CONTROL COMMISSION

Casino Licensees

Financial Stability of Casino Licensees and Applicants

Adopted Amendment: N.J.A.C. 19:43-4.1

Proposed: April 19, 1993 at 25 N.J.R. 1672(b).
Adopted: June 3, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: June 7, 1993 as R.1993 d.317, **without change.**

Authority: N.J.S.A. 5:12-69, 70b, h and l, and 84.

Effective Date: July 6, 1993.
Expiration Date: December 21, 1997.

Summary of Public Comments and Agency Responses:
Comments were received from the Division of Gaming Enforcement ("the Division") and the Sands Hotel & Casino ("the Sands").

COMMENT: Both the Division and the Sands stated general support for the proposed amendment.

RESPONSE: Accepted.

Full text of the adoption follows.

19:43-4.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings:

...

"Casino bankroll" means cash maintained in the casino, excluding any funds necessary for the normal operation of the casino, such as change banks, slot hopper fills, slot booths, cashier imprest funds and redemption area funds.

...

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Gaming Equipment
Slot Drop Boxes

Adopted Amendments: N.J.A.C. 19:45-1.1, 1.10, 1.32, 1.36, 1.37, 1.38, 1.42, 1.43, and 1.44; N.J.A.C. 19:46-1.26 and 1.33

Adopted Repeal: N.J.A.C. 19:46-1.25

Proposed: April 5, 1993 at 25 N.J.R. 1503(b).
Adopted: June 3, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: June 7, 1993 as R.1993 d.318, **without change.**

Authority: N.J.S.A. 5:12-63(c), 69(a), 70(l), 99(a)10-11 and 100(c).

Effective Date: July 6, 1993.
Operative Date: October 15, 1993.
Expiration Date: August 15, 1997, N.J.A.C. 19:45; April 15, 1998, N.J.A.C. 19:46.

Agency Note: Although this proposal will become effective on July 6, 1993, the Commission has specified an operative date of October 15, 1993. This will allow licensees sufficient time to obtain and install the equipment needed to comply with this proposal.

Summary of Public Comment and Agency Response:

COMMENT: Trump's Castle Casino Resort (Castle), Bally's Park Place, Inc. (Bally's), and Adamar of New Jersey, Inc. (TropWorld) objected to the requirement of a locking drop box for certain higher denomination slot tokens. Castle believes its procedure, which involves using only supervisors to pick up and count slot tokens in denominations of $10.00 and above, offers superior control over the proposed locking drop box.

TropWorld contends that such boxes would be unnecessary if casino licensees would establish additional security measures for the removal of these higher denomination slot tokens, including using additional security and casino accounting personnel, having the surveillance department videotape removal of the slot drop buckets, and using a clear sealed plastic hopper bag to secure the slot tokens when the slot drop bucket is removed from the slot machine.

TropWorld also notes such boxes might also cause more mechanical problems, such as coin jams and overflows of slot tokens into the slot base. TropWorld also believes that when filled with slot tokens, such a box would be heavier and more unwieldy than a slot drop bucket. For these reasons, TropWorld suggests the use of such boxes should be optional for those licensees which have instituted the abovementioned or other additional security measures approved by the Commission.

RESPONSE: Rejected. The use of supervisory personnel or additional security measures in the removal process does not, in the Commission's opinion, resolve the basic security problems created by the use of slot drop buckets to collect higher denomination slot tokens. In its opinion, these problems are best solved by the proposed locking slot boxes. Such boxes are now being used voluntarily by Harrah's Marina and Caesars, without any of the possible mechanical difficulties or operational problems which have been raised as concerns by other licensees.

COMMENT: Castle, Bally's, Marina Associates (Harrah's) and Boardwalk Regency Corporation (Caesars) objected to the proposed requirement in N.J.A.C. 19:45-1.36(e)1, which permits only slot supervisors to access slot machines using slot tokens in denominations of $25.00 and above.

Castle believes this requirement will create a tremendous burden to its slot department and great inconvenience to its slot patrons because it would apply to all hopper fills and machine malfunctions. Castle also contends the present procedure, which creates an audit trail by the completion of a Machine Entry Authorization Log, provides sufficient security. Bally's indicated that in its opinion, the supervisory requirement is unnecessary and would serve no regulatory purpose, because it would not necessarily provide any additional security.

RESPONSE: Rejected. Requiring a locking slot drop box will not, by itself, provide the desired security for higher denomination slot tokens if the slot machine's hopper can be easily accessed. The hopper, which holds loose slot tokens for jackpot payouts, cannot, as a practical matter, be sealed off or enclosed. The hopper must remain accessible for hopper fills, coin jams, and other mechanical problems. This is why the proposal requires supervisory personnel to open the slot machine, which is where the hopper is located. Since typically, less than one percent of the slot machines on a casino floor use higher denomination tokens, the supervisory requirement should not interfere with or disrupt slot operations.

COMMENT: Castle noted that a correction should be made to N.J.A.C. 19:45-1.42(c)2, where the reference to "cage supervisor" should be "slot cash supervisor" instead.

RESPONSE: Rejected. The reference to "cage supervisor" is correct and should not be changed. That reference in proposed N.J.A.C. 19:45-1.42(c)2 is not new, but is a recodification of N.J.A.C. 19:45-1.42(c)2ii.

COMMENT: Bally's objected to the requirement in N.J.A.C. 19:45-1.43(c) that would require a Commission inspector to be present when a slot drop box is opened.

RESPONSE: Rejected. This amendment simply extends to slot drop boxes the existing regulatory requirements applicable to slot drop buckets, the contents of which have always been required to be counted and recorded in the presence of a Commission inspector. However, unlike a slot drop bucket, a slot drop box will have to be opened before its contents can be counted. The amendments to N.J.A.C. 19:45-1.43(c) make it clear that these locking slot drop boxes must be opened in the presence of a Commission inspector. This is the same requirement that the Commission has always imposed upon the opening, counting and recording of the drop boxes now used at table games. See N.J.A.C. 19:45-1.33(c).

Full text of the adoption follows:

19:45-1.1 Definitions

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

...

"Slot drop bucket" is defined in N.J.A.C. 19:45-1.36.

"Slot drop box" is defined in N.J.A.C. 19:45-1.36.

"Slot machine" means any mechanical, electrical or other device, contrivance or machine which, upon insertion of a coin, token or similar object therein, or upon payment of and consideration whatsoever, is available to play or operate, the play or operation of which, whether by reason of the skill of the operator or application of the element of chance, or both, may deliver or entitle the person playing or operating the machine to receive cash or tokens to be exchanged for cash or to receive any merchandise or thing of value, whether the payoff is made automatically from the machine or in any other manner whatsoever.

"Slot machine drop" means the amount of coins and slot tokens in a slot drop bucket or a slot drop box, and cash in a slot cash storage box, if applicable.

...

19:45-1.10 Closed circuit television system: surveillance department control; surveillance department restrictions

(a) (No change.)

(b) The closed circuit television system shall include, but need not be limited to, the following:

1. Light sensitive cameras with zoom, scan, and tilt capabilities to effectively and clandestinely monitor in detail and from various vantage points, the following:

i.-vii. (No change.)

viii. The movement of cash, gaming chips and plaques, drop boxes, slot cash storage boxes, slot drop boxes and slot drop buckets in the establishment;

ix.-x. (No change.)

2.-5. (No change.)

(c)-(h) (No change.)

19:45-1.32 Count rooms; characteristics

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

(d) The count room designated for counting contents of slot drop buckets and slot drop boxes, if a different room than that used for counting contents of drop boxes and slot cash storage boxes, shall

meet all requirements herein except for the audio capabilities. In addition, the room shall contain either a fixed-door type or hand-held metal detector to inspect all persons exiting the count room.

19:45-1.36 Slot machines and bill changers; coin and slot token containers; slot cash storage boxes; entry authorization logs

(a) Each slot machine located in a casino shall have the following coin or slot token containers:

1. A container, known as a payout reserve container ("hopper"), in which coins or slot tokens are retained by the slot machine to automatically pay jackpots or to dispense change as directed by a bill changer connected to the slot machine, provided, however, that the hopper shall not retain slot tokens issued pursuant to N.J.A.C. 19:46-1.33(c)2;

2. A container, known as a slot drop bucket or slot drop box, to collect coins or slot tokens that are retained by the slot machine and are not used to make change or automatic jackpot payouts. Each slot drop bucket or slot drop box shall be identified by a number which corresponds to the asset number of the slot machine, and which is permanently imprinted on or affixed to the outside of the slot drop bucket or slot drop box in numerals at least two inches high; and

3. On those slot machines to which a bill changer is attached, a container known as a slot cash storage box, in which currency accepted by the bill changer is retained.

(b) A slot drop bucket shall be housed in a locked compartment separate from any other compartment of the slot machine. The compartment shall have two locks, the keys to which shall be different from each other and from the keys utilized to secure all other compartments of the slot machine. One key to the compartment shall be maintained and controlled by a Commission inspector. The second key to the compartment shall be maintained and controlled by the casino security department in a secure area within that department, access to which may be gained only by a casino security department supervisor.

(c) A slot drop box shall have:

1. A slotted opening through which coins and tokens can be deposited;

2. A device that will automatically close and lock the slotted opening upon removal of the slot drop box from the slot machine; and

3. Two separate locks securing the contents of the slot drop box, the keys to which shall be different from each other. The key to one of the locks shall be maintained and controlled by a Commission inspector. The key to the second lock, which shall also be different from the keys utilized to secure the compartments of the slot machine and the slot drop box, shall be maintained and controlled by the accounting department in a secure area within that department, access to which may be gained only by a supervisor in that department.

(d) A slot drop box shall be housed in a locked compartment separate from any other compartment of the slot machine. The area in which the slot drop box is located shall be secured by two separate locks, the design, location and operation of which shall be approved by the Commission, and the keys to which shall be different from each other. The key to one of the locks securing this area shall be maintained and controlled by a Commission inspector. The key to the second lock, which shall also be different from the keys utilized to secure any other compartments of the slot machine and the contents of the slot drop box, shall be maintained and controlled by the casino security department in a secure area within that department, and access to the key may be gained only by a supervisor in that department.

(e) Any slot machine equipped to accept slot tokens in denominations of $25.00 or more shall:

1. Be opened only by a slot department supervisor or a supervisor thereof; and

2. Utilize a slot drop box, rather than a slot drop bucket.

(f) Each slot machine equipped to accept slot tokens issued pursuant to N.J.A.C. 19:46-1.33(c)2 shall contain a separate slot drop bucket or slot drop box to collect and retain all such slot tokens that are inserted into the slot machine.

Recodify (d) as (g) (No change in text.)

(h) The key to one of the locks securing the area where the slot cash storage box is located shall be maintained and controlled by a Commission inspector. The key to the second lock to such area, which key shall also be different from the keys securing the contents of the slot cash storage box, shall be maintained and controlled by the casino security department or the slot department in a secure area within that department. Access to the key may be gained only by a supervisor in that department, provided, however, that if the slot department controls the key, the supervisor of the slot department may issue the key to a casino security department supervisor, who may give it to appropriate casino security department personnel only for the purpose of participating in the transportation of slot cash storage boxes, pursuant to N.J.A.C. 19:45-1.17.

(i) Keys to each slot machine, or any device connected thereto which may affect the operation of the slot machine, with the exception of the keys to the compartments housing the slot drop bucket and to the locks securing the areas where the slot cash storage box and slot drop box are located, shall be maintained in a secure place and controlled by the slot department. Keys to slot machines equipped to accept slot tokens in denominations of $25.00 or more shall be maintained and controlled by the slot department in a secure area within that department, access to which may be gained only by a supervisor in that department.

(j) Any key removed from a department's secure area pursuant to (b), (c), (d), (h) and (i) above shall be returned no later than the end of the shift of the department member to whom the key was issued, and the department shall establish a sign-out and sign-in procedure approved by the Commission for all such keys removed.

(k) Unless a computer which automatically records the information specified in (k)1, 2, and 3 below is connected to the slot machines in the casino, the following entry authorization logs shall be maintained by the casino licensee;

1. Whenever it is required that a slot machine or any device connected thereto which may affect the operation of the slot machine be opened, with the exception of a bill changer, certain information shall be recorded on a form to be entitled "Machine Entry Authorization Log." The information shall include, at a minimum, the date, time, purpose of opening the machine or device, and the signature of the authorized employee opening the machine or device. The Machine Entry Authorization Log shall be maintained in the slot machine and shall have recorded thereon a sequential number and a manufacturer's serial number or the asset number of that slot machine.

2. Whenever it is required that a progressive controller not housed within the cabinet of a slot machine be opened, the information specified in (k)1 above shall be recorded on a form to be entitled "Progressive Entry Authorization Log." The Progressive Entry Authorization Log shall be maintained in the progressive unit and shall have recorded thereon a sequential number and serial number of the progressive controller.

3. With the exception of the transportation of slot cash storage boxes, pursuant to N.J.A.C. 19:45-1.17(a), whenever it is required that a bill changer, other than a separate slot cash storage box compartment, be opened, the entry shall be made on a form to be entitled "Bill Changer Log." The entry shall include, at a minimum, the date, time, purpose of opening the bill changer, and the signature of the authorized employee opening the bill changer. The Bill Changer Log shall be maintained in the bill changer and shall have recorded thereon a sequential number and the serial number or asset number of the bill changer.

19:45-1.37 Slot machines and bill changers; identifications; signs; meters

(a) (No change.)

(b) Unless otherwise authorized by the Commission, each slot machine in a casino shall be equipped with the following:

1. (No change.)

2. A mechanical, electrical or electronic device, to be known as a "drop meter," that continuously and automatically counts the number of coins or slot tokens dropped into the machine's slot drop bucket or slot drop box; provided, however, that for machines equipped to accept slot tokens issued pursuant to N.J.A.C. 19:46-1.33(c)2, a separate "drop meter" shall count the number of such slot tokens dropped into the separate slot drop bucket or slot drop box required by N.J.A.C. 19:45-1.36(i);

3.-4. (No change.)

(c)-(i) (No change.)

19:45-1.38 Slot machines and bill changers; location; movements

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

(d) Prior to removing a slot machine from the gaming floor, the slot drop bucket or slot drop box shall be removed and transported to the count room, and all meters shall be read and recorded in conformity with the procedures set forth in N.J.A.C. 19:45-1.42. Any coins or tokens in the payout reserve container and the corresponding hopper storage area shall be removed, transported, and counted with the slot drop bucket or slot drop box contents; however, a slot machine may be removed from the casino with coins or tokens contained therein when removal of such coins is precluded by mechanical or electrical difficulty. The removal and transportation to the count room of such coins or tokens must be completed immediately after the slot machine is opened.

(e)-(f) (No change.)

19:45-1.42 Removal of slot drop buckets, slot drop boxes and slot cash storage boxes; meter readings

(a) For each slot machine and attached bill changer on the gaming floor, the slot drop bucket, slot drop box and slot cash storage box shall be removed at least once a week on specific days and at times designated by the casino licensee on a schedule which shall be filed with the Commission and the Division. No slot drop bucket, slot drop box or slot cash storage box shall be emptied or removed from its compartment at other than the times specified on such schedule except with the express approval of the Commission. Prior to emptying or removing any slot drop bucket, slot drop box or slot cash storage box, a casino licensee shall notify the Commission and the surveillance department of the transportation route that will be utilized.

(b) Slot drop buckets, slot drop boxes and slot cash storage boxes shall be removed from their compartments in a slot machine or bill changer, in the presence of a Commission inspector, by at least three employees, two of whom shall be members of the casino security department, and one of whom shall be a member of the accounting department.

(c) Procedures and requirements for removing slot drop buckets, slot drop boxes and slot cash storage boxes from the casino shall be as follows:

1. The slot drop bucket, slot drop box or slot cash storage box shall be removed from its compartment and an empty slot drop bucket, slot drop box, or slot cash storage box shall be placed into the compartment, and if applicable, a unique identification number shall be assigned and recorded for the slot cash storage box, either upon its insertion or removal, after which the compartment shall be closed and locked;

2. All slot drop buckets, slot drop boxes and slot cash storage boxes removed from compartments shall be transported by at least the employees described in (b) above and a Commission inspector directly to, and secured in the count room for the counting of their contents, except that slot cash storage boxes and slot drop boxes removed on an emergency basis shall be transported by at least a Commission inspector, a casino security department member and a cage supervisor or count room supervisor directly to and secured in the count room; and

3. All persons participating in the removal of slot drop buckets, slot drop boxes and slot cash storage boxes, except for casino security department employees and representatives of the Commission and Division, shall wear as outer garments only a full-length, one-piece pocketless garment with openings only for the arms, feet and neck.

(d) In addition to complying with the procedures included in (b) and (c) above, a casino licensee shall submit to the Commission for approval its procedures detailing how the slot drop bucket, slot drop box and slot cash storage box for each slot machine and attached bill changer on the gaming floor will be emptied or removed from its compartment when the casino is open to the public for 24 hours. Such submission shall include at least the following:

1. How patrons will be notified that a slot machine will be closed for emptying or removing slot drop buckets, slot drop boxes or slot cash storage boxes;

2. (No change.)

3. How the area will be secured while the slot drop buckets, slot drop boxes or slot cash storage boxes are emptied or removed; and

4. How the compartments in which the full slot drop buckets, slot drop boxes or slot cash storage boxes are transported, will be secured while they are in the casino.

(e) Accounting department employees with no incompatible functions shall, at least once a week read and record on a Slot Meter Sheet the numbers on the in-meter, drop meter, jackpot meter, manual jackpot meter and change meter. Accounting department employees shall periodically read and record on a Slot Meter Sheet the numbers on the bill meters in accordance with a schedule established by the casino licensee and approved by the Commission, but in no event shall the casino licensee be required to read and record the bill meters more than once a week. These procedures shall be performed in conjunction with the removal and replacement of the slot drop buckets, slot drop boxes or slot cash storage boxes prior to opening the slot machines for patron play.

(f)-(g) (No change.)

19:45-1.43 Slot count; procedure for counting and recording contents of slot drop buckets and slot drop boxes

(a) The contents of slot drop buckets and slot drop boxes shall be counted and recorded in conformity with this section.

(b) Each casino licensee shall file with the Commission and the Division the specific times during which the contents of slot drop buckets and slot drop boxes removed from compartments are to be counted and recorded, which shall be immediately after removal from their compartments.

(c) The opening, counting and recording of the contents of slot drop buckets and slot drop boxes shall be performed in the presence of a Commission inspector by at least three employees ("Count Team") with no incompatible functions. To gain entrance to the count room, the Commission inspector shall present an official identification card containing his photograph issued by the Commission.

(d)-(e) (No change.)

(f) Immediately prior to opening and counting the contents of the slot drop buckets and slot drop boxes, the doors to the count room shall be securely locked, the counting devices to be used shall be checked for accuracy by employees with no incompatible functions, and, except as required by (j)2 below, no person shall be permitted to enter or leave the count room, except during a normal work break or in an emergency, until the entire counting and recording process is completed. During a work break or in the event of an emergency, the counting and recording process shall be discontinued unless the appropriate number of personnel as described in (c) above are present.

(g)-(h) (No change.)

(i) Procedures and requirements for conducting the count shall be the following:

1. Before each slot drop bucket or slot drop box is emptied, one count team member shall hold it up in full view of the closed circuit television camera and the person recording the count, to properly record the number thereon;

2. The contents of each slot drop bucket or slot drop box shall be emptied, counted and recorded separately and such procedures shall at all times be conducted in full view of the closed circuit television cameras located in the count room;

3. The contents of each slot drop bucket or slot drop box shall be emptied separately into either a machine that automatically

counts the coins or slot tokens placed therein, or a scale that automatically weighs the coins or slot tokens placed therein;

4. Immediately after the contents of each slot drop bucket or slot drop box are emptied into either the count machine or scale, or if currency, on a table in the count room, the inside of the slot drop bucket or slot drop box shall be held up to the full view of the closed circuit television camera and shall be shown to at least one other slot count team member and the Commission inspector to assure all contents of the slot drop bucket or slot drop box have been removed;

5. As the contents of each slot drop bucket or slot drop box are counted by the count machine or weighed by the scale, one member shall record on the Slot Win Sheet, or supporting document, the asset number of the slot machine to which the slot drop bucket or slot drop box contents corresponds, if not preprinted thereon, and the number of coins or slot tokens, or the weight of the coin or slot tokens. If the coin or slot token value is not converted until after the count is completed, the conversion shall be prepared and the dollar value of the drop shall be entered by denomination on the Slot Win Report;

6. After the contents of all the slot drop buckets and slot drop boxes are counted or weighed and recorded, each count team member shall sign the Slot Win Sheet or other document as approved by the Commission attesting to their involvement in the county;

7. After the contents of all the slot drop buckets and slot drop boxes are counted or weighed and recorded, any count team employees not required pursuant to (i)7ii below may be permitted to exit the count room, provided that the following requirements are satisfied:

i.-iv. (No change.)

v. A security department employee shall check all persons leaving the count room with a metal detector, in the presence of a Commission inspector, at a location approved by the Commission and Division; and

8. At the conclusion of the count process, any slugs that have been found shall be delivered to an agent of the Division together with a copy of the Slug Report. The Slug Report shall be a three-part form, at a minimum, which shall include the date, the total number of slugs received and the signature of the preparer, and shall be distributed as follows:

i.-iii. (No change.)

(j) Procedures and requirements at the conclusion of the count shall be the following:

1. (No change.)

2. The wrapped coin and slot tokens removed from the slot drop buckets and slot drop boxes shall be counted in the count room, in the presence of a count team member and a Commission inspector, by a cage cashier or master coin bank cashier, prior to the cashier having access to the information recorded on the Slot Win Sheet. The cage cashier or master coin bank cashier shall attest by signature on the Slot Win Sheet to the accuracy of the amount of coin and slot tokens received from the slot machines; after which the Commission inspector shall sign the Slot Win Sheet evidencing the inspector's presence during the count and the fact that both the cashier and count team have agreed on the total amount of coin and slot tokens counted. The coin and slot tokens thereafter shall remain in the custody of cage cashiers or master coin bank cashiers.

3.-4. (No change.)

5. The preparation of the Slot Win Sheet shall be completed by accounting department employees with no incompatible functions as follows:

i. Compare for agreement, for each slot machine, the number of coins or slot tokens counted and recorded by the count team to the drop meter reading recorded on the Slot Meter Sheet;

ii.-vi. (No change.)

6. (No change.)

19:45-1.44 Computer recordation and monitoring of slot machines

(a) (No change.)

(b) The computer permitted by (a) above shall be designed and operated to automatically perform the function relating to slot machine meters in the casino as follows:

1. (No change.)

2. Record the number and total value of coins or slot tokens issued pursuant to N.J.A.C. 19:46-1.33(c)1 deposited in the slot drop bucket or slot drop box of the slot machine;

3. Record the number and total value of slot tokens issued pursuant to N.J.A.C. 19:46-1.33(c)2 deposited in the separate slot drop bucket or slot drop box of the slot machine required by N.J.A.C. 19:45-1.36(i);

4.-8. (No change.)

(c) (No change.)

19:46-1.25 (Reserved)

19:46-1.26 Slot machines and bill changers; identification; signs; meters; other devices

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

(c) Unless otherwise authorized by the Commission, each slot machine in a casino shall be equipped with the following:

1. (No change.)

2. A mechanical, electrical or electronic device, to be known as a "drop-meter," that continuously and automatically counts the number of coins or slot tokens dropped into the machine's slot drop bucket or slot drop box; provided, however, for machines equipped to accept slot tokens issued pursuant to N.J.A.C. 19:46-1.33(c)2, a separate "drop meter" shall count the number of such slot tokens dropped into the separate container required by N.J.A.C. 19:45-1.36(i);

3.-6. (No change.)

(d)-(i) (No change.)

19:46-1.33 Issuance and use of tokens for gaming in slot machines

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

(c) Slot tokens approved for issuance by a casino licensee pursuant to this section shall either be:

1. (No change.)

2. Issued in accordance with a complimentary distribution program authorized pursuant to N.J.A.C. 19:45-1.46 and:

i. (No change.)

ii. Retained in a separate container in such slot machines in accordance with N.J.A.C. 19:45-1.36(i);

iii.-iv. (No change.)

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Personnel Assigned to the Operation and Conduct of Gaming and Slot Machines
Cashier's Cage, Satellite Cages; Master Coin Bank, Coin Vaults
Accounting Controls for the Cashier's Cage, Master Coin Bank and Coin Vault
Adopted Amendments: N.J.A.C. 19:45-1.12, 1.14, 1.15 and 1.46

Proposed: April 19, 1993 at 25 N.J.R. 1673(a).

Adopted: June 3, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: June 7, 1993 as R.1993 d.319, **without change.**

Authority: N.J.S.A. 5:12-63(c), 69(a), 70(g) and 99(a).

Effective Date: July 6, 1993.

Expiration Date: August 15, 1997.

Summary of Public Comments and Agency Responses:

COMMENT: Boardwalk Regency Corporation (Caesars), which originally suggested the proposal, supported its adoption, as did Greate Bay Hotel and Casino, Inc. (Sands).

RESPONSE: Accepted.

COMMENT: Adamar of New Jersey, Inc. (TropWorld) supported the proposal, and additionally suggested that the applicable regulations should be amended to permit changepersons to exchange currency and coupons for currency.

RESPONSE: The comment was accepted in part as to TropWorld's support of the present proposal, but rejected as to the latter suggestion, which has merit, but is beyond the scope of the present proposal, which only involves slot attendants. The suggested amendment will be proposed by the Commission in the near future.

COMMENT: The Division of Gaming Enforcement (Division) objected to the proposal, questioning the need for it, and contending that the extent of the changemaking problem, which the proposal is intended to address, has not been sufficiently demonstrated.

RESPONSE: The comment is rejected. The Commission is satisfied that the proposed arrangement, which was originally suggested by Boardwalk Regency Corporation (Caesars), is a reasonable and appropriate way to resolve what at least one licensee perceives as a potential problem. Moreover, no casino licensee would be required to have its slot attendants exchange currency; the arrangement is completely optional, and a licensee does not have to utilize it if it does not wish to do so.

COMMENT: The Division also objects to the proposal because it would create a diversity of reporting requirements for slot attendants, who would report to slot supervisors for their slot duties, and to the cage supervisors for their changemaking duties, contrary to the departmental chain of command objective in N.J.S.A 5:12-99a(3). The Division contends that this would create problems in the prioritization of tasks.

RESPONSE: The comment is rejected. The two functions are not incompatible, and do not conflict with the criteria in N.J.A.C. 19:45-1.11(a). The function of operating and maintaining slot machines and bill changers is separate and easily distinguished from the proposed changemaking function, and should be permitted. Additionally, it should be noted that although N.J.A.C. 19:45-1.14(a)4 requires the cage to reconcile the imprest funds used by slot attendants, the cage supervisor does not supervise the slot attendants who carry these funds. If shortages or other problems are discovered by the cage supervisor, it is the slot department that would deal with the problem and the slot attendant in question.

COMMENT: The Division is also concerned that the proposal would further increase the duties of slot attendants, whose responsibilities have already been increased to include the monitoring of bill changers attached to the slot machines, and who may also have, under a regulatory proposal now pending, expanded responsibilities in connection with the payment of certain hand-paid slot jackpots. The Division questions whether these additional duties and responsibilities may distract or deter slot attendants from performing their primary responsibilities under N.J.A.C. 19:45-1.12(g)2. In this regard the Division also notes that Caesars has requested another regulatory amendment, which requests that members of other departments be allowed access to bill changers, to assist busy slot attendants in clearing bill jams and otherwise maintaining the bill changers.

RESPONSE: The comment is rejected. As long as the integrity and security of casino operations are properly maintained, the manner in which a casino chooses to carry out its changemaking procedure should, to the extent possible under the requirements of the Casino Control Act, be left to a casino's business discretion.

Full text of the adoption follows.

19:45-1.12 Personnel assigned to the operation and conduct of gaming and slot machines

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

(g) The following personnel shall be used to operate the slot department in an establishment:

1. (No change.)

2. Slot attendants shall be the persons assigned the responsibility for the operation of slot machines and bill changers, including, but not limited to, participating in manual jackpot payouts and filling payout reserve containers. At the discretion of the casino licensee, slot attendants may also accept currency and coupons from patrons in exchange for currency obtained from an imprest fund issued by the cashiers' cage or the master coin bank in accordance with internal control procedures approved by the Commission.

3.-5. (No change.)

(h)-(i) (No change.)

19:45-1.14 Cashiers' cage; satellite cages; master coin bank; coin vaults

(a) Each establishment shall have on or immediately adjacent to the gaming floor a physical structure known as a cashiers' cage ("cage") to house the cashiers and to serve as the central location in the casino for the following:

1.-2. (No change.)

3. The receipt, distribution, and redemption of gaming chips and plaques in conformity with this chapter;

4. The issuance, receipt and reconciliation of imprest funds used by slot attendants in the acceptance of currency and coupons from patrons in exchange for currency in conformity with this chapter; and

Recodify existing 4. as 5. (No change in text.)

(b) Each establishment shall have within the cage or in such other area as approved by the Commission a physical structure known as a master coin bank to house master coin bank cashiers. The master coin bank shall be designed and constructed to provide maximum security for the materials housed therein and the activities performed therein and serve as the central location in the casino for the following:

1. The custody of currency, coin slot tokens, forms, documents and records normally generated or utilized by master coin bank cashiers, slot cashiers, changepeople, and slot attendants;

2. The exchange of currency, coin, coupons and slot tokens for supporting documentation;

3. The responsibility for the overall reconciliation of all documentation generated by master coin bank cashiers, slot cashiers, changepeople, and slot attendants;

4.-5. (No change.)

(c)-(h) (No change.)

19:45-1.15 Accounting controls for the cashiers' cage, satellite cages, coin bank and coin vault

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

(c) The cashiers' cage and any satellite cage shall be physically segregated by personnel and function as follows:

1.-3. (No change.)

4. Reserve cash ("main bank") cashiers' functions shall be, but are not limited to, the following:

i.-v. (No change.)

vi. Issue, receive and reconcile imprest funds used by slot attendants;

vii. Exchange currency for coupons and currency from slot attendants;

Recodify existing vi.-viii. as viii.-x. (No change in text.)

5. Master coin bank cashiers' functions shall be, but are not limited to, the following:

i. Receive currency, coin, slot tokens, gaming chips, and coupons from slot cashiers in exchange for proper documentation;

ii.-iii. (No change.)

iv. Issue, receive and reconcile imprest funds used by slot attendants;

v. Exchange currency for coupons and currency from slot attendants;

Recodify iv.-v. as vi.-vii. (No change in text.)

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

19:45-1.46 Procedure for control of coupon redemption and other complimentary distribution programs

(a)-(i) (No change.)

(j) Coupons shall be redeemed in the following manner:

1. Coupons redeemable for cash or slot tokens shall only be redeemed by changepersons or at the slot change booths or the cashiers' cage located on the casino floor. A changeperson, slot cashier or general cage cashier shall accept the coupons in exchange for the stated amount of cash or slot tokens and shall cancel the coupons upon acceptance. Coupons redeemable for cash may also be redeemed by slot attendants, who shall accept the coupons in exchange for the stated amount of currency and shall cancel the

coupon upon acceptance. Cancellation of coupons by changepersons and slot attendants shall be in a manner that will permit subsequent identification of the individual who accepted and canceled the coupon.

2. Redeemed coupons shall be maintained by the slot or general cashier and shall be exchanged with the Main or Master Coin Bank for a like amount of cash at the conclusion of gaming activity each day, at a minimum.

3. Notwithstanding the above, an automated coupon redemption machine may be utilized to accept coupons, provided that the acceptance of coupons by an automated coupon redemption machine complies with the procedures and requirements established by this section and N.J.A.C. 19:45-1.46A.

4. Coupons redeemable for simulcast wagers shall only be accepted by casino pari-mutuel cashiers at the simulcast counter in exchange for the simulcast wagers stated on the coupons. Cancellation of coupons by casino pari-mutuel cashiers shall be in a manner that permits subsequent identification of the individual who accepted and cancelled the coupon. Redeemed coupons shall be maintained by the casino pari-mutuel cashier, or in the simulcast vault, and shall be exchanged with the Main Bank for a like amount of cash not less frequently than at the conclusion of each day.

(k)-(o) (No change.)

(a)

CASINO CONTROL COMMISSION

Internal Controls
Acceptance of Tips or Gratuities
Adopted Amendment: N.J.A.C. 19:45-1.19

Proposed: April 19, 1993 at 25 N.J.R. 1674(a).
Adopted: June 3, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: June 7, 1993 as R.1993 d.320, **without change**.

Authority: N.J.S.A. 5:12-63c, 69a and 100o.

Effective Date: July 6, 1993.
Expiration Date: August 15, 1997.

Summary of Public Comments and Agency Responses:

Comments were received from the Division of Gaming Enforcement ("Division"), Trump's Castle Casino Resort ("Trump's Castle") and the Sands Hotel and Casino ("the Sands").

COMMENT: The Division stated its support for the proposal, noting that the amendment accurately codifies a 1989 Commission ruling (*In the Matter of Trump's Castle Assoc.*, Commission Resolution 89-87).

RESPONSE: The Commission agrees, as evidenced by the adoption herein.

COMMENT: Trump's Castle and the Sands stated their general support for the proposed amendment.

RESPONSE: Accepted.

Full text of the adoption follows.

19:45-1.19 Acceptance of tips or gratuities from patrons

(a) (No change.)

(b) All tips and gratuities allowed dealers in the casino and casino simulcasting facility shall be:

1.-2. (No change.)

3. Placed in a common pool for distribution pro rata among all dealers with the distribution based upon the number of hours each dealer has worked.

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

(e) In determining the number of hours which an employee has worked for purposes of tip pool distribution, a casino licensee may, in its discretion, establish standards for distribution which include hours of vacation time, personal leave time or any other authorized leave of absence in the number of hours worked by each employee. Any such standards shall apply uniformly to all employees, except that the casino licensee may establish different standards for full-time or part-time employees.

(b)

CASINO CONTROL COMMISSION

Notice of Administrative Correction
Accounting and Internal Controls
Slot Count; Procedure for Counting and Recording Contents of Slot Drop Buckets
N.J.A.C. 19:45-1.43

Take notice that the Casino Control Commission has discovered errors in the text of N.J.A.C. 19:45-1.43(j)2. The three uses of the term "slot cashier" in that paragraph were changed to "master coin bank cashier" effective May 6, 1991 (see 22 N.J.R. 3205(a) and 23 N.J.R. 1499(a)); the change was not, however, reflected in the Code update containing that rulemaking. This notice of administrative correction is published pursuant to N.J.A.C. 1:30-2.7.

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

19:45-1.43 Slot count; procedure for counting and recording contents of slot drop buckets

(a)-(i) (No change.)

(j) Procedures and requirements at the conclusion of the count shall be the following:

1. (No change.)

2. The wrapped coin and currency removed from the slot drop buckets shall be counted in the count room, in the presence of a count team member and a Commission inspector, by a cage cashier or [slot] **master coin bank** cashier, prior to the cashier having access to the information recorded on the Slot Win Sheet. The cage cashier or [slot] **master coin bank** cashier shall attest by signature on the Slot Win Sheet to the accuracy of the amount of coin and currency received from the slot machines; after which the Commission inspector shall sign the Slot Win Sheet evidencing the inspector's presence during the count and the fact that both the cashier and count team have agreed on the total amount of coin and currency counted. The coin and currency thereafter shall remain in the custody of cage cashiers or [slot] **master coin bank** cashiers.

3.-6. (No change.)

TRANSPORTATION

(c)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Speed Limits
Route U.S. 9 In Ocean County
Adopted Amendment: N.J.A.C. 16:28-1.41

Proposed: May 3, 1993 at 25 N.J.R. 1834(a).
Adopted: June 7, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: June 11, 1993 as R.1993 d.327, **without change**.

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-98.

Effective Date: July 6, 1993.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows.

16:28-1.41 Route U.S. 9

(a) (No change.)

(b) The rate of speed designated for the certain parts of State highway Route U.S. 9 (and excluding Garden State Parkway

Authority sections) described in this subsection shall be established and adopted as the maximum legal rate of speed for both directions of traffic:

1.-17. (No change.)

18. 35 miles per hour between Lakeside Drive and 800 feet north of Lacey Road, Lacey Township (approximate milepost 81.10 to 83.94); thence

19. 45 miles per hour between the Lacey Township-Berkeley Township line (Cedar Creek) and 350 feet south of John F. Kennedy Boulevard (approximate mileposts 83.94 to 88.63); thence

20. 35 miles per hour between 350 feet south of John F. Kennedy Boulevard and the Berkeley Township-Pine Beach Borough, Blackwood Borough line (Mizzen Avenue) (approximate mileposts 88.63 to 89.45); thence

21.-32. (No change.)

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping Routes N.J. 28 in Somerset County and N.J. 56 in Salem County

Adopted Amendments: N.J.A.C. 16:28A-1.19 and 1.98

Proposed: May 3, 1993 at 25 N.J.R. 1836(a).

Adopted: June 7, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Filed: June 11, 1993 as R.1993 d.328, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-197.4, 39:4-197.5, 39:4-198 and 39:4-199.

Effective Date: July 6, 1993.

Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

16:28A-1.19 Route 28

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

(d) The certain parts of State highway Route 28 described in this subsection shall be designated and established as Restricted Parking Space, for the use of persons who have been issued special Vehicle Identification Cards by the Division of Motor Vehicles. No other person shall be permitted to park in these areas. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established handicapped parking spaces:

i. (No change.)

ii. Restricted parking in the Borough of Somerville, Somerset County:

(1) Handicapped parking (Main Street) on the north side beginning at a point 81 feet west of Maple Street to a point 22 feet westerly therefrom.

(2) Handicapped parking (Main Street) on the north side beginning at a point 278 feet west of Davenport Street to a point 22 feet westerly therefrom.

(3) Handicapped parking (Main Street) on the south side beginning at a point 298 feet east of Union Street to a point 22 feet easterly therefrom.

(e) The certain parts of State highway Route 28 described in this subsection shall be designated and established as "Time Limit Parking" zones where parking is prohibited at all times except in the areas designated below. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established Time Limit Parking zones:

1. In Roselle Park Borough, Union County:

i. (Westfield Avenue) westbound on the northerly side, between Sheridan Avenue and Sherman Avenue and between Camden Street and Dalton Street:

(1) One hour time limit parking, between 9:00 A.M. and 5:00 P.M. Monday, Tuesday, Thursday, Friday and Saturday; and

(2) One hour time limit parking, between 11:00 A.M. and 5:00 P.M. Wednesday.

ii. (Westfield Avenue) eastbound on the southerly side, between Sherman Avenue and Sheridan Avenue:

(1) One hour time limit parking, between 9:00 A.M. and 5:00 P.M. Monday, Tuesday, Wednesday, Friday and Saturday; and

(2) One hour time limit parking, between 11:00 A.M. and 5:00 P.M. Thursday.

2. In the Borough of Somerville, Somerset County:

i. Along the north side:

(1) From North Bridge Street to the prolongation of the westerly curb line of Union Street:

(A) One hour time limit parking all hours;

(2) From Mechanic Street to Grove Street, and from the prolongation of the easterly curb line of Union Street to Doughty Avenue:

(A) Two hours time limit parking all hours Monday through Saturday:

ii. Along the south side:

(1) From Union Street to South Bridge Street:

(A) One hour time limit parking all hours Monday through Saturday.

(2) From Doughty Avenue to Union Street, and from Warren Street to Hamilton Street;

(A) Two hours time limit parking all hours, Monday through Saturday.

(f) The certain parts of State highway Route 28 described in this subsection shall be designated and established as "angle parking space(s) and time limit parking" zones where parking is prohibited at all times except in the areas designated and at times specified. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following parking space(s):

1. In the Borough of Somerville, Somerset County;

i. Angle parking:

(1) (Main Street) on the north side:

(A) From Grove Street to North Bridge Street.

(2) (Main Street) on the south side:

(A) From South Bridge Street to Warren Street.

ii. Time limit parking:

(1) From South Bridge Street to Warren Street on the south side:

(A) One hour time limit parking, during all hours Monday through Saturday including Sundays and Holidays.

(2) From Grove Street to North Bridge Street on the north side:

(A) One hour time limit parking, during all hours Monday through Saturday including Sundays and Holidays.

(g) The certain parts of State highway Route 28 described in this subsection shall be designated and established as "no parking during certain hours" zones. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following "no parking during certain hours" zones:

1. In the Borough of Somerville, Somerset County:

i. Along both sides:

(1) Within the entire corporate limits from 9:00 P.M. to 6:00 A.M. every day all year, for trucks only; and

(2) Within the entire corporate limits from 2:00 A.M. to 6:00 A.M. for all other types of vehicles every day all year, excluding Sundays and Holidays.

16:28A-1.98 Route 56

(a) The certain parts of State highway Route 56 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.

1.-3. (No change.)
4. No stopping or standing in Pittsgrove Township, Salem County:
i. Along both sides for the entire length within the corporate limits, including all ramps and connections thereto which are under the jurisdiction of the Commissioner of Transportation, except in areas covered by other parking restrictions adopted in accordance with the Administrative Procedures Act and N.J.A.C. 1:30.

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping
Route N.J. 57 in Warren County and N.J. 77 in Cumberland County
Adopted Amendments: N.J.A.C. 16:28A-1.36 and 1.41

Proposed: May 3, 1993 at 25 N.J.R. 1835(a).
Adopted: June 7, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: June 11, 1993 as R.1993 d.329, **with technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-138.1, 39:4-198 and 39:4-199.

Effective Date: July 6, 1993.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:

The Department received a comment from Richard Nathan, Nathan Theatres, West Orange, New Jersey, concerning the parking restrictions being imposed on Route N.J. 57, the Boulevard (N.J. 31-57 Connector), in the Borough of Washington, Warren County.

There was no comment received on the parking restrictions being imposed on Route N.J. 77 in the City of Bridgeton, Cumberland County.

COMMENT: "We run a motion picture theatre on the Boulevard and the only parking we have for our patrons is "on street" parking. Our theatre hours are only in the evening from 7:00 P.M. to midnight, the traffic problem only occurs from 7:00 A.M. to 10:00 A.M. and 3:00 P.M. to 6:00 P.M. Doing away with all parking in this area at all times is effectively putting us out of business."

RESPONSE: It is not, nor has it ever been, the Department's intent of putting anyone out of business. However, because of reasons of safety, statutory zoning, the travelled area being a live lane and the area having been signalized with a mandatory, left-turning lane, parking was restricted from the north side only. Parking is, however, authorized on the south side.

COMMENT: Your proposal erroneously quotes the resolution passed by the Borough of Washington.

RESPONSE: The resolution referred to in the rule proposal was that adopted by the City of Bridgeton, Cumberland County. (Resolution No. 67-92)

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***).

16:28A-1.36 Route 57

(a) The certain parts of State highway Route 57 described in this subsection are designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs must be erected.

1.-2. (No change.)

3. No stopping or standing in Washington Borough, Warren County:

i.-ii. (No change.)

iii. Along the north side:

(1) From the easterly curb line of Route N.J. 31 to the westerly curb line of the Boulevard (N.J. 31-57 Connector), including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in areas covered by other parking restrictions adopted in accordance with the Administrative Procedure Act and N.J.A.C. 1:30.

4.-6. (No change.)

(b) (No change.)

(c) (No change in text.)

16:28A-1.41 Route 77

(a) The certain parts of State highway Route 77 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.

1. No stopping or standing in Cumberland County:

i. In the City of Bridgeton:

(1) Southbound on the westerly side:

(A)-(B) (No change.)

(C) Beginning at the southerly curb line of Highland Avenue to a point 149 feet south therefrom.

(D) Beginning at the northerly curb line of American Avenue to a point 115 feet north therefrom.

(E) Beginning at the northerly curb line of Monroe Street to a point 71 feet north therefrom.

(F) Beginning at the northerly curb line of Penn Street to a point 163 feet north therefrom.

(G)-(H) (No change.)

(I) Beginning at a point 120 feet north of the northerly curb line of Irving Avenue to a point 130 feet south of the southerly curb line of Irving Avenue.

Recodify existing (L)-(N) as (J)-(L) (No change in text.)

Recodify existing (Q) and (R) as ***(M) and (N)*** (No change in text.)

(2) Northbound on the easterly side:

Recodify existing (B)-(C) as (A)-(B) (No change in text.)

(C) From a point 125 feet south of the southerly curb line of Irving Avenue to a point 70 feet north of the northerly curb line of Irving Avenue.

(D) (No change in text.)

Recodify existing (G)-(J) as (E)-(H) (No change in text.)

Recodify existing (M)-(Q) as ***(I)-(M)*** (No change in text.)

2.-5. (No change.)

(b) The certain parts of State highway Route 77 described in this subsection shall be designated and established as "no parking" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:

1. In the City of Bridgeton, Cumberland County:

i. Along the southbound (westerly) side:

(1) Far side bus stops:

(A) (No change.)

(B) North Street—Beginning at the southerly curb line of North Street and extending 105 feet southerly therefrom.

(C) Irving Avenue—Beginning at the southerly curb line of Irving Avenue and extending 105 feet southerly therefrom.

(D) Commerce Street—Beginning at the southerly curb line of Commerce Street and extending 105 feet southerly therefrom.

(2) Near side bus stops:

(A) Mulford Drive—Beginning at the northerly curb line of Mulford Drive and extending 105 feet northerly therefrom.

(B) Highland Avenue—Beginning at the northerly curb line of Highland Avenue and extending 105 feet northerly therefrom.

(C) Cumberland Avenue—Beginning at the northerly curb line of Cumberland Avenue and extending 105 feet northerly therefrom.

(D) Monroe Street—Beginning at the northerly curb line of Monroe Street and extending 105 feet northerly therefrom.

(E) Penn Street—Beginning at the northerly curb line of Penn Street and extending 105 feet northerly therefrom.

(F) Morton Street—Beginning at the northerly curb line of Morton Street and extending 105 feet northerly therefrom.

ii. Along the northbound (easterly) side:

(1) Far side bus stops:
(A) Commerce Street—Beginning at the northerly curb line of Commerce Street and extending 105 feet northerly therefrom.
(B) Washington Street—Beginning at the northerly curb line of Washington Street and extending 105 feet northerly therefrom.
(C) Myrtle Street—Beginning at the northerly curb line of Myrtle Street and extending 105 feet northerly therefrom.
(D) Highland Avenue—Beginning at the northerly curb line of Highland Avenue and extending 105 feet northerly therefrom.
(E) Mulford Drive—Beginning at the northerly curb line of Mulford Drive and extending 105 feet northerly therefrom.
(2) Near side bus stops:
(A) Irving Avenue—Beginning at the southerly curb line of Irving Avenue and extending 105 feet southerly therefrom.
(B) Orchard Street—Beginning at the southerly curb line of Orchard Street and extending 105 feet southerly therefrom.
(C) Seibel Street—Beginning at the southerly curb line of Seibel Street and extending 105 feet southerly therefrom.
(D) Penn Street—Beginning at the southerly curb line of Penn Street and extending 105 feet southerly therefrom.
(E) Cumberland Avenue—Beginning at the southerly curb line of Cumberland Avenue and extending 105 feet southerly therefrom.
2.-4. (No change.)
(c)-(d) (No change.)

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Weight Limits
Route N.J. 173 in Hunterdon County
Adopted Repeal and New Rule: N.J.A.C. 16:30-6.3

Proposed: May 3, 1993 at 25 N.J.R. 1838(a).
Adopted: June 7, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: June 11, 1993 as R.1993 d.330, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 27:7-21.

Effective Date: July 6, 1993.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

16:30-6.3 Route 173
(a) Trucks traveling on the certain parts of State highway Route 173 described in this subsection shall be limited to a weight limit of 10 tons registered gross weight, except for the pick-up and delivery of materials.
1. In the Borough of Bloomsbury, Hunterdon County:
i. For the entire length:
(1) Eastbound—From the junction of Route N.J. 173 eastbound and the Route I-78-U.S. 22 Eastbound Ramp (milepost 0.0) to the intersection of Route N.J. 173 and Main Street (milepost 3.68).
(2) Westbound—From the intersection of Route N.J. 173 and Main Street (milepost 3.68) to a point 1,638 feet west of the westerly curb line of Voorhees Road.

(b)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Mid-Block Crosswalk
Route N.J. 28 in Somerset County
Adopted Amendment: N.J.A.C. 16:30-10

Proposed: May 3, 1993 at 25 N.J.R. 1838(b).
Adopted: June 7, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: June 11, 1993 as R.1993 d.331, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-34.

Effective Date: July 6, 1993.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

SUBCHAPTER 10. MID-BLOCK CROSSWALK

16:30-10.1 Route 28
(a) The certain parts of Route 28 described in this subsection shall be designated as a mid-block crosswalk:
1. In Somerville Borough, Somerset County:
i. Main Street—From a point 252 feet east of the easterly curb line of Union Street to a point six feet easterly therefrom; and
ii. Main Street—From a point 360 feet east of the easterly curb line of North Middaugh Street to a point six feet easterly therefrom.

(c)

DIVISION OF TRANSPORTATION ASSISTANCE OFFICE OF AVIATION
Licensing of Aeronautical and Aerospace Facilities
Adopted Repeal and New Rules: N.J.A.C. 16:54

Proposed: July 20, 1992 at 24 N.J.R. 2542(a).
Adopted: June 14, 1993. by William D. Ankner, Director, Division of Policy and Capital Programming, Department of Transportation.
Filed: June 15, 1993 as R.1993 d.348, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.A.C. 27:1A-5, 27:1A-6, 6:1-29 and 6:1-43.

Effective Date: July 6, 1993.
Expiration Date: July 6, 1998.

Summary of Public Comments and Agency Responses:
The New Jersey Department of Transportation (Department) is adopting rules to implement the provisions of Titles 6 and 27 of the New Jersey Statutes, concerning the "Licensing of Aeronautical and Aerospace Facilities," as new rules N.J.A.C. 16:54.

As drafted, the new rules would require the aeronautical facility owner to furnish the Office of Aviation with documented procedures governing the operation of the aeronautical facility. The procedures would improve safety, enhance operations, and minimize adverse impacts to adjacent property owners and the community. These procedures would be reviewed by the Office of Aviation and either be approved or returned with changes. The Office of Aviation would also be empowered to suspend or revoke any aeronautical facility license for noncompliance.

Furthermore, the proposed rules enhance the coordination between the Office of Aviation, the aeronautical facility owner, and the local governing body. This coordination should promote a cooperative relationship and minimize adversarial applications.

The proposed new rules were the subject of a preproposal which appeared in the New Jersey Register at 24 N.J.R. 80(a). The preproposal was initiated in an effort to obtain the maximum possible public input and to assist in its fact-finding efforts.

The public comment period on the preproposal closed on March 7, 1992, by which time 14 comments were received, which were used by the Department in the development and refinement of the proposed repeal and new rules, which appeared in the New Jersey Register at 24 N.J.R. 2542(a). A public hearing concerning the proposed new rules was held on August 7, 1992, at 1:00 P.M. at the New Jersey Department of Transportation, Multi-Purpose Room, 1035 Parkway Avenue, Trenton, New Jersey. Twenty people presented comments. Tom Johnson, of the Department's Bureau of Community Involvement, conducted the hearing. There was no formal recommendation made by Mr. Johnson to the Department. The Department evaluated the verbal and/or written comments submitted at the hearing, and the reponses are included in this adoption. The public comment period for the proposed new rules closed on August 7, 1992. In view of the numerous comments and additional requests for extensions received from the municipalities and the general public, the Department extended the comment period to September 18, 1992, and said notice appeared in the New Jersey Register at 24 N.J.R. 3026(a), and an additional extension was granted to January 15, 1993, which notice appeared at 24 N.J.R. 4025(a). Secondary notice was given by publishing notices in newspapers of general circulation and by direct mailing the full text of the proposal to affected agencies and interested parties. To date, 206 comments were received and a petition with 400 signatures, which included some of the commenters.

As a result of the public hearing held, and the comments received, the Department has further amended the rule to effect changes in phraseology, and administrative changes not requiring additional public notice and comment.

The amendments are summarized as follows:

N.J.A.C. 16:54-1.3, was amended to add the definitions of "accident," "appropriate governing body," "effective runway length," "incident," and "safety zone area" to clearly define terms used in the text which could potentially be interpreted to mean other than what is applicable within the chapter. Additionally, "aeronautical activity," "airport layout plan," "approach departure path," "safety area," "special use aeronautical facility," and "vertical flight aircraft" were amended to provide specificity to those terms as used in the industry.

N.J.A.C. 16:54-2.1 was amended at subparagraph (a)1 to rephrase wording which commenters felt was not clear. Additionally at (a)iv, notification requirements were added to ensure that the county in which the airport is located is notified of any proposed action. At subparagraphs (a)2i(2), ii(2), iv(2), vi(2), vii(2) and ix(2)were amended to correct an omission to accurately identify the longitude and latitude of the facility. Paragraph (a)6 was revised to ensure clarity and provide clarification that appropriate governing bodies are provided the opportunity for input concerning a facility application.

N.J.A.C. 16:54-2.2 was amended to add the specific citation governing the application requirements.

N.J.A.C. 16:54-2.3 was amended at subsections (a) and (b) to provide clarification to definitively state that the office requires the legal notice. Our intent has always been to require notice. Subsection (d) was added to clarify waiver provisions for notice requirements.

N.J.A.C. 16:54-2.4 was amended to effect administrative changes based upon comments received.

N.J.A.C. 16:54-2.5 was amended to effect administrative changes based upon comments received.

N.J.A.C. 16:54-2.8 was amended to include written notice by the office to the appropriate governing body of intent to renew the license for all public use aeronautical facilities.

N.J.A.C. 16:54-2.9 was amended to require that the licensee provide written notice to the appropriate governing body concerning transfers.

N.J.A.C. 16:54-3.1 was amended to effect administrative changes and to clarify inspection procedures and to conform language to statutory requirements concerning residents or agent requirements.

N.J.A.C. 16:54-3.2 was recodified to clarify this section and delete definitions, some of which have been added to N.J.A.C. 16:54-1.3.

N.J.A.C. 16:54-3.3 was amended to add clarification of land use provisions for aeronautical activities, and expanded to include auxiliary sites for restricted use aeronautical facilities.

N.J.A.C. 16:54-3.4 was amended to provide administrative changes for clarity in language.

N.J.A.C. 16:54-4.2 was amended to add an explanation of the requirements regarding effective length.

N.J.A.C. 16:54-4.3 was amended to specify design requirements for restricted use aeronautical facilities, which were not previously specifically defined, which were incorporated in response to significant comments from the industry.

N.J.A.C. 16:54-4.4 was amended to specify design requirements for special use aernoautical facilities which were not previously specifically defined, which were incorporated in response to a significant number of comments received from the industry.

N.J.A.C. 16:54-5.1 was amended to delete minimum airman requirements and to clarify the procedure for reporting accidents and incidents. In response to numerous comments, specific procedures were added for air traffic patterns and noise abatement programs.

N.J.A.C. 16:54-5.2 was amended to clearly define the role of the Federal government regarding air space.

N.J.A.C. 16:54-6.1 was amended to delete part of subsection (e) which was recodified to N.J.A.C. 16:54-6.2 for clarification and ease of reading.

N.J.A.C. 16:54-6.2 was amended to include procedures applicable to applications for a temporary facility pending permanent licensure, and further amended to clarify the time period requirements for receipt of applications.

N.J.A.C. 16:54-6.3 was amended to provide for auxiliary sites for aeronautical facilities.

N.J.A.C. 16:54-6.5 was amended to clarify the provisions for operational standards and to correctly list the minimum pilot qualifications for operations at temporary facilities.

N.J.A.C. 16:54-8.3 was amended to clarify the suspension provisions.

N.J.A.C. 16:54-9.1 was amended to clarify the positions authorized to suspend aeronautical licenses.

The hearing record may be reviewed by the public by contacting Mr. Charles L. Meyers, Administrative Practice Officer, Department of Transportation, 1035 Parkway Avenue, Trenton, New Jersey 08625, telephone (609) 530-2041.

The following individuals submitted written comments and/or made oral comments at the public hearing: For commenters whose name or affiliation was indecipherable, the Department has inserted blanks.

Paul J. Albert—Randolph, New Jersey
Loretta E. Alkalay—US Federal Aviation Administration
Eugene A. Baker—Princeton, New Jersey
M.W. Balas—Alpha, New Jersey
Veronica Balas—Alpha, New Jersey
George Balcato—Newton, New Jersey
Tom Baldwin—Bloomsburg, New Jersey
Joseph A. Banghat, Jr.—Belvidere, New Jersey
Frank J. Bastone—Fairfield, New Jersey
Mac Bauerlein—Andover Township, New Jersey
James R. Bird—Township of Lumberton, New Jersey
John O. Bennett, III—Ansell, Zaro, Bennett, Kenney & Grim
Tom Boland—Linden, New Jersey
Richard M. Bouck—Belvidere, New Jersey
William Boyce—Englishtown, New Jersey
Joseph V. Burakevich—Skillman, New Jersey
Richard L. Calvert—Sparta, New Jersey
Barbara L. Cannon—Mayor, Old Bridge Township
Rudolph Chalow—Rudy's Airport, Vineland, New Jersey
Edward A. Chittenden—Princeton, New Jersey
Diana B. Chittenden—Princeton, New Jersey
James D. Chrive—Belvidere, New Jersey
Barry P. Clark—Administrator, Readington Township
John J. Clute, Jr.—Ewing, New Jersey
Lanky L. Collins—Belvidere, New Jersey
George L. Conrad—Flying Farmers
John J. Coscia—Delaware Valley Reg. Planning Commission
John F. Coulahan—Bridgewater, New Jersey
Allen Dashevsky—Jamesburg, New Jersey
Sharon Dashevsky—Jamesburg, New Jersey
William E. Davis—Heliport Systems, Inc.
Howard M. Dees—Bridgewater, New Jersey
Irene F. Dees—Bridgewater, New Jersey
Tom Delaney—South Plainfield, New Jersey
Justin J. Dintino—NJ State Police
Doc Dodenburgl, Sr.—Belvidere, New Jersey
Joseph M. Doerer—Whitehouse Station, New Jersey
Alfred A. Donst—Belvidere, New Jersey

Alfred A. Donst, Jr.—Belvidere, New Jersey
Bethany Donst—Belvidere, New Jersey
Erin P. Donst—Belvidere, New Jersey
Jacqueline F. Donst—Belvidere, New Jersey
Mary L. Donst—Belvidere, New Jersey
William G. Dressel Jr.—New Jersey State League of Municipalities
Barbara Dressler—Princeton, New Jersey
H.W. Dressler—Princeton, New Jersey
Paul P. Dudley—Linden Air Services Corp.
James E. Duncan—Jacobstown, New Jersey
Bill Dunn—Aircraft Owners and Pilots Assn.
Richard N. Dutson—Bristol-Meyers Squibb Co.
Harry B. Eastburn, Jr.—Delran, New Jersey
Carol Emmers—Watchung, New Jersey
Jeffrey S. Evans—Columbia, New Jersey
Lewis B. Finch, Jr.—Millville Municipal Airport
Robert T. Fiorelli—Bayville, New Jersey
David M. Fischer—Belvidere, New Jersey
George W. Fisher—Attorney, Montgomery Township, New Jersey
Wayne G. Fox CH (Capt)—Cedar Knolls, New Jersey
Joan Fratezi—Belvidere, New Jersey
Loraine Fritts—Great Meadows, New Jersey
Mamie Fritts—Long Valley, New Jersey
Rodger A. Fritts—Great Meadows, New Jersey
A. Douglas Gilbert—Belvidere, New Jersey
Bill Geisler—CRASH
Kristina P. Hadinger—Mason, Griffin & Pierson
Laury C. Hamler—Belvidere, New Jersey
David Hartung—Phillipsburg, New Jersey
Gerald E. Haughey—Morristown, New Jersey
Bill Haylton—Belvidere, New Jersey
Dave Herbert—Monmouth County, New Jersey
Ellen L. Herr—Sparta, New Jersey
Robert J. Hickey—Washington, New Jersey
Dorothy Highland—Princeton, New Jersey
Joseph Highland—Princeton, New Jersey
Dawn Hockenbury—Belvidere, New Jersey
Donna Hockenbury—Belvidere, New Jersey
Joanne Hockenbury—Belvidere, New Jersey
Lina Hockenbury—Belvidere, New Jersey
Will Hockenbury—Belvidere, New Jersey
Bartley G. Hoebel—Princeton, New Jersey
Jeffrey W. Hoffman—Flemington, New Jersey
John G. Hoffman—Carney's Point, New Jersey
Mike Hollander—Communities For Responsible Airport Mgmt.
Edward P. Hopes—Belvidere, New Jersey
Kristi L. Hopes—Belvidere, New Jersey
Michael T. Horterman—Phillipsburg, New Jersey
George E. Huey—Frenchtown, New Jersey
Michael G. Huey—Princeton, New Jersey
Melvin J. Hughes, II—Phillipsburg, New Jersey
Richard J. Igobuonio—Washington, D.C.
Carl L. Jones—Belvidere, New Jersey
Renee Jones—Columbia, New Jersey
Walter Jones—Columbia, New Jersey
Doug Joseph Kieryck—Englishtown, New Jersey
Mary Ann Kieryck—Englishtown, New Jersey
Laurie Kieryck—Englishtown, New Jersey
L. Kocon—Oak Ridge, New Jersey
Shirley Koepke—Bridgewater, New Jersey
Wilbur Koepke—Bridgewater, New Jersey
Lourimar A. Kalulewsky—Phillipsburg, New Jersey
Brian W. Konash—Mahwah, New Jersey
Christopher M. Konash—Mahwah, New Jersey
Karen H. Konash—Mahwah, New Jersey
Lawrence B.Konash—Mahwah, New Jersey
John Koony—Columbia, New Jersey
Robert G. Kroll, D.D.S.—Millburn, New Jersey
Kevin C. Lambert—Belvidere, New Jersey
Charles E. Lascari—Hackensack Medical Center
T.T. Lehman—Belvidere, New Jersey
William B. Leavens—Mid-Atlantic Aviation Coalition
Kenneth R. Leota—Howell, New Jersey
Brad J. Levine—Princeton, New Jersey
Brian Levine—Hopewell, New Jersey
Marice Levine—Princeton, New Jersey
William C. Ludt—Princeton, New Jersey
Jon Lyman—Watchung, New Jersey
Earl W. MacPherson, Jr.—Pennsville, New Jersey
David M. MacRae, PhD.—Princeton, New Jersey
Ronald F. Maisch—Morristown, New Jersey
Thomas Malman—Pitney, Hardin, Morristown, New Jersey
Joseph B. Martin—JK Martin Developers, Inc.
Robert L. Matthews—Far Hills, New Jersey
Dean W. Maurer—Mid-Atlantic Aviation Coalition
D. Jane Melchionda—Whitehouse Station, New Jersey
James Mikesh, Sr.—Blairstown, New Jersey
Allen E. Molnar—Westfield, New Jersey
Roger Moog—DVRPC
Lorelei N. Mottese—Mayor, Lincoln Park Borough
James P. Muldoon—The Port Authority of New York and New Jersey
Mr. & Mrs. A. Myskowski—Bridgewater, New Jersey
Susan Nagle—Aero New Jersey
Maryann L. Nergaard—Woolson, Sutphen, Anderson & Nergaars
Kenneth Nierenberg—Princeton Aero Corp.
Naomi Nierenberg—Princeton Aero Corp.
Walter B. Nixon—Lawrenceville, New Jersey
Brian A. Nolan—Mayor, Rocky Hill Borough
J. Michael Nolan, Jr.—Pitney, Hardin, Kipp & Szuch
Edward O'Neil—Belvidere, New Jersey
Tom Oerman—Pittstown, New Jersey
Jerry Palin—Princeton, New Jersey
Raymond Pantano—Mullica Hill, New Jersey
Margaret Pensak—Whitehouse Station, New Jersey
John PePorlis—Phillipsburg, New Jersey
Cynthia E. Perillo—Bridgewater, New Jersey
Michael Perillo—CRASH
Patricia A. Pickrel—Princeton, New Jersey
Arthur M. Poyer—Blairstown, New Jersey
Jeffrey Priest—Princeton, New Jersey
Joan W. Priest—Princeton, New Jersey
Charles Promso—Phillipsburg, New Jersey
Georgia L. Puttock—Lakehurst, New Jersey
Robert G. Puttock—Lakehurst, New Jersey
James D. Quinn—Bridgewater, New Jersey
James P. Ranapul—Phillipsburg, New Jersey
John D. Rankin, Esq.—Princeton, New Jersey
Brian K. Reeder—Belvidere, New Jersey
Rich Reinhart—List Counselors, Inc.
Thomas C. W. Roberts—Princeton, New Jersey
Lisa Rohrbough—Hackettstown, New Jersey
Fritz Rowe—Belvidere, New Jersey
John C. Rowe—Belvidere, New Jersey
Richard K. Rusby, Belvidere, New Jersey
Ran Sam—Mount Hopatcong, New Jersey
Frank Scangarella, Esq.—Attorney, Lincoln Park Borough
Mark K. Schilling—Moorestown, New Jersey
Beverly Schneider—East Windsor, New Jersey
Christopher Schneider—East Windsor, New Jersey
Hans Schneider—Plainsboro, New Jersey
Johann Schneider—The Balloonary, Avon-By-The-Sea, New Jersey
Jay C. Schull—Phillipsburg, New Jersey
David C. Shaw—Monmouth County Shade Tree Commission
Bettie Smith—Belvidere, New Jersey
John H. Smith—Belvidere, New Jersey
Willis Smith—Long Valley, New Jersey
David P. Spais—Southampton, New Jersey
F. Lloyd Staats—Mid-Jersey Helicopter
Michael J. Stachowitz
Donna H. Steele—Princeton, New Jersey
Mitchell J. Stoddard—Morristown Airport Pilots Assn.
J. Strand—Clinton, New Jersey
Brett J. Suey—Alpha, New Jersey
Raymond Syms—Raymond A. Syms Associates
Wath Summerod—Hackettstown, New Jersey
John Tate—Port Murray, New Jersey
Marlene Tattle—Princeton, New Jersey
Randy K. Trimmer—Belvidere, New Jersey
Linda Vuch—Hackettstown, New Jersey
Dan Walker—Somerset Air Service

Grace J. Wallace—Vienna, New Jersey
John Warms—Mayor, Montgomery Township
F. L. Wehran, Sr.—Sun Valley Farm
Carl Welch—Hackettstown, New Jersey
Elise Wendel—Princeton, New Jersey
Heide Wendel—Princeton, New Jersey
T. M. Wendel—Princeton, New Jersey
Frank P. Werner—Jamesburg, New Jersey
Russell Widener—Washington, New Jersey
Gene Wilhowsky—Augusta, New Jersey
Ruth Wilhowsky—Augusta, New Jersey
Geraldine E. Wille—Jersey Shore Balloon Pilots Assn.
Paul T. Wille—Gentle Giant Sport Balloons
Keith Wolfinger—Belvidere, New Jersey
Richard C. Woodbridge—Mayor, Princeton Township
Louise M. Zipfel—Flemington, New Jersey
83 Cherry Brook Drive—Princeton, New Jersey
212 Cherry Brook Drive—Princeton, New Jersey
Petition with 400 signatures, some of which were commenters.

The comments exactly as they were received by the Department, and the Department's responses, are enumerated below:

N.J.A.C. 16:54-1

COMMENT: In order to preserve our existing public and special use airports and insure their operation as safe reliable partners in the state's economic development, it is absolutely necessary that the State of New Jersey provide leadership and standardization of facilities and their safety and operating features, through the proposed regulations which will reconfirm and clarify the jurisdiction of the Office of Aviation. If left without state regulation, the airport infrastructure will be vulnerable to irregularities in physical features and operation, as well as the potential for undue constraints from local government and development pressure. Safety today as well as economic prosperity tomorrow will certainly be compromised.

A strong and stable general aviation infrastructure is necessary throughout New Jersey, not only to alleviate business and recreational flights which would be forced to use our commercial airports, but to provide the mobility necessary to insure the economic development in the future which will result in jobs and the high quality of life our citizens deserve. Therefore, the NJAAC support, as presented in their entirety, the proposed "Licensing of Aeronautical and Aerospace Facilities" N.J.A.C. 16:54.

COMMENT: It is of utmost importance that these or substantially similar regulations be adopted and enforced by the State. We understand that the State is charged by the Federal government with the responsibility to regulate public use facilities that are a valuable component of both intrastate and interstate transportation networks. The users, operators, and owners of these facilities charge you with the responsibility to protect them. Only when public use airport owners, municipal officials, and airport neighbors are on common ground with sensible, standardized, enforceable regulations will there be an end to the incessant stupid squabbling over turf rights and "who makes the rules".

COMMENT: It is necessary for the Office of Aviation to be much more cognizant and considerate of legitimate local concerns, whether they be land use, environmental, noise or safety. The Office of Aviation does not have as its singular purpose the promotion of aviation; rather the interests of public safety, the safety of persons and property on the ground are of, at the very least, equal concern. In weighing the above concerns, the Department should heed its own laudable objective, as set forth in the introductory comments to the rule proposal, specifically that the rules are intended to "strengthen the role of the Department in the uniform public control and oversight of aeronautical facilities in New Jersey and ensure that interests of communities and the nonaviation public are fully considered." In their present form the rules simply do not meet that intent.

COMMENT: New Jersey should have uniform, State-wide aviation regulations, as a means of avoiding chaos caused by municipal regulations concerning public use airports.

RESPONSE: The Office recognizes its duties and responsibilities under the statute. These rules do, in fact, set forth the standards by which the Office will discharge its duties. It is the intent and purpose of these rules to strengthen the role of the Department in the uniform public control and oversight of aeronautical facilities in New Jersey and ensure that interests of communities and the non-aviation public are fully considered.

N.J.A.C. 16:54-1.1

COMMENT: We take strong exception to the statements in Subchapter 1, the section: your assertion that ultimate authority resides with the Commissioner as regards land use, we take exception that ultimate authority for flight facility resides with the Commissioner.

RESPONSE: This language reflects the authority granted by the legislature to the Commissioner under N.J.S.A. 6:1-1 et seq. The rules in N.J.A.C. 16:54 state that, where the State is not preempted by the Federal government, the ultimate authority over the regulation and licensing of aeronautical facilities in New Jersey resides with the Commissioner.

COMMENT: Unless the document is changed completely to reflect a combined control between local municipalities and DOT, effective response to both, the communities' and aviation needs will be unattainable.

COMMENT: Recommend that the FAA impose regulations concerning local airports, rather than the State or local municipalities in view of all the problems created locally.

COMMENT: The licensing proposal does not consider the needs of local municipalities and residents around airports. It allows no impact of local ordinances and does not consider the issue of "home rule". It absolutely shows no concern for the health, safety, and welfare of the people who live by and around airports.

COMMENT: Regulations transfer land use authority to the New Jersey Department of Transportation.

RESPONSE: The Commissioner will work with municipalities to consider valid expressions of municipal interest. The Commissioner will weigh local interests, examine whether contemplated actions are compatible with surrounding land uses, and will consult local land ordinances and authorities before rendering a decision. However, the Legislature has placed the responsibility for the licensing and regulation of aeronautical facilities with the Commissioner and that responsibility must be discharged by the Commissioner.

COMMENT: The New Jersey State Police Aviation Unit requests a waiver from all licensing rules described in N.J.A.C. 16:54, or recommends the Department include language designating the State Police as a self-certifying entity to license and inspect its own facilities.

COMMENT: The revised rules should include the authority for the State Police to temporarily license heliports and helipads (for their own use).

RESPONSE: The Commissioner of Transportation is charged with the responsibility to license aeronautical facilities under N.J.S.A. 6:1-44. To ensure that those licensing provisions are carried out uniformly and with full consideration for protection of the public health and the safety of those participating in aeronautical activities, the Commissioner must retain that licensing authority. Therefore, it would be inappropriate to issue a blanket waiver or allow any other agency to license such facilities. A separate regulatory provision regarding temporary "Official Use Helistops" declared by government officials or law enforcement agencies is being reviewed and may be promulgated.

N.J.A.C. 16:54-1.1(b)

COMMENT: The doctrine of preemption is a doctrine of law which recognizes that the Federal government has exclusive powers over certain matters. This section states that "rules specified in this chapter, if not in conformity with the laws, rules and regulations concerning aeronautics set forth by the Federal Aviation Administration or the National Aeronautics and Space Administration, are subject to preemption." This, however, fails to recognize that the source of preemption is not merely a lack of conformity with already existing laws, rules and/or regulations.

RESPONSE: The State understands, recognizes, and accepts the doctrine of Federal preemption, where it is applicable. The State has no intention of asserting jurisdiction in areas preempted by the Federal government.

N.J.A.C. 16:54-1.2

COMMENT: Do not adopt any rules which would require every hot air balloon launch site used for sport and pleasure flying to be licensed. Doing so would add unnecessary danger and take away landowners' rights to enjoy their property.

COMMENT: The rules being proposed will put such a hardship on balloon pilots that they will have to give up ballooning or leave the State. Hot air balloon pilots are licensed by the FAA. Any State regulation or rule concerning balloning is considered preempted by the FAA regulations.

COMMENT: There is no need or purpose to be gained by licensing launch sites for balloons. It is considered best to keep the balloonists spread out rather than clustered at licensed sites which would create too many landings in the same region.

RESPONSE: Licensing of aeronautical facilities for all types of aircraft including balloons, is the responsibility of the Commissioner in accordance with N.J.S.A. 6:1-29 et seq. The Department licenses specific launch sites, but also allows balloonists to use auxiliary launch sites, in accordance with N.J.A.C. 16:54-3.4(e), thereby allowing the launch sites to be spread out, or dispersed, as the operator selects.

COMMENT: The following should be added: "Due to the nature of free balloon flight, any balloon launching from an appropriately licensed facility or from out of state is inferred to be permitted to exercise touch and go's (at least in non congested areas) and to make final landings at any suitable site with the landowner's permission or when that is not possible the pilot will take all actions to ensure the safety of the balloon, passengers and all persons on the ground and protect all property rights. The aircraft owner and/or pilot shall be limited to liability and trespass as provided for forced landings in the Uniform Aeronautics Law, N.J.S.A. 6:2-7."

RESPONSE: The regulation of aircraft in flight is within the purview of the FAA and the State recognizes their preemption in the area. The suggestions made by the commenters would place the State in conflict with preemptive Federal regulations. Regarding forced landings, the provisions of N.J.S.A. 6:2-7 already apply.

N.J.A.C. 16:54-1.2(a)

COMMENT: With the utilization of emergency hospital helistops, consideration should be given to the inclusion of the following hospital helistops:

Hospital helistop—Public Use
Hospital helistop—Restricted Use
Hospital helistop—Special Use

RESPONSE: All helicopter landing facilities are adequately addressed within the three license categories. The changes proposed have standardized the categories of licensing throughout the rules, and we believe that this standard format is easier to follow.

N.J.A.C. 16:54-1.2(a)3

COMMENT: Change to read: **"Lighter than air balloon port,"** and delete i through iii.

RESPONSE: The requirement for multiple categories of facilities is uniform throughout the chapter. It is based on the need to set more stringent standards for facilities which are available to the general public. There is no necessity for those standards to be required of all restricted and special use balloonports.

N.J.A.C. 16:54-1.2(b)

COMMENT: This section should be revised to read, "effective 180 days after the state has provided the standard format for the Aeronautical Activities Standard, all license applications and renewal applications shall be required to comply with the requirements of this rule".

RESPONSE: The Office of Aviation will make available a sample format in outline form which may be used as a guide in preparing the required manuals. However, the requirement to prepare such manuals within the allotted time rests with the licensee.

N.J.A.C. 16:54-1.2(c) and (d)

COMMENT: The manner by which the Office of Aviation will determine compliance or lack thereof of existing facilities is unclear. Will existing licensees be required to comply with the requirements of 16:54-2.1 or will their compliance with the new standards simply be reviewed in conjunction with a renewal application governed by 16:54-2.8, which, most inappropriately, does not provide for local certification or notice to the public.

RESPONSE: Existing licensees will be governed by the provisions set forth in N.J.A.C. 16:54-2.8, Renewals, and will not be subject to making a renewal application.

N.J.A.C. 16:54-1.3

COMMENT: The definition of "aeronautical activity" is extremely problematic. It must be read in conjunction with [N.J.A.C.] 16:54-3.2(a). The Department needs to identify clearly and concisely what is meant by "aeronautical activities."

RESPONSE: To clarify the definition of aeronautical activity, the explanatory examples have been removed from N.J.A.C. 16:54-3.2(a) and incorporated into the definitions section, N.J.A.C. 16:54-1.3.

COMMENT: The definitions for "approach/departure path" and "landing and takeoff area" contain a notation to the effect that the definition applies only to vertical flight aircraft or helicopters. As interpreted, the terms do not apply to airports accommodating fixed wing aircraft. If so, how are approach slopes and landing area definitions applicable to fixed wing aircraft operations?

RESPONSE: The limitation to "vertical flight aircraft only" has been eliminated for approach/departure paths and the wording clarified to more specifically define the approach and departure path, in accordance with applicable FAA advisory circulars, which were incorporated by reference in the proposal. Landing and takeoff area definitions do pertain only to vertical flight operations. Approach slopes and landing area requirements for fixed wing aircraft operations are covered in N.J.A.C. 16:54-4.2.

N.J.A.C. 16:54-1.3

COMMENT: The definition for Effective Runway Length has been deleted. Is it no longer required?

RESPONSE: The definition was inadvertently omitted from the proposal and is being included on adoption.

COMMENT: The definition section leaves out the definition of the safety zone, which may be defined in the Air Safety and Hazard and Zoning Act of 1983 and the Air Safety Act as amended. It would be a worthwhile addition to your definitions.

RESPONSE: The definition has been added, since it is already law, for purposes of clarity. In addition, the definition of safety area has been clarified.

COMMENT: The definitions "restricted use aeronautical facility" and "special use aeronautical facility" are confusingly similar and are virtually identical. The term "private use" is contained within the term "special use", and it appears that the same restrictions defined under "special use aeronautical facility" would apply to all "private use" airports. This is overly restrictive because it sweeps all private airports into being limited to ". . . designated aircraft by specified individuals, as authorized by the Office of Aviation."

RESPONSE: The definition of "special use aeronautical facility" has been amended to clarify the difference between the two types of facilities mentioned by the commenter. The term "private use" is not included in the definition of special use aeronautical facility. However, the intent of the rule is to include what was formerly known as a private air field (PAF) into the Special Use Aeronautical Facility license category. The restrictions on special use facilities are no different that those previously placed on PAFS.

COMMENT: Recommend that "Balloon port" be deleted from the definition of aeronautical facility because balloons are not motor driven aviation.

RESPONSE: A balloon is a certificated aircraft, as defined by the FAA, and, therefore, it is appropriate that balloon ports be addressed in these rules.

N.J.A.C. 16:54-1.3

COMMENT: The definition of "approach/departure path" should be modified to read "pertains to operation of vertical flight aircraft except balloons;" because balloons do not have, nor are they capable of a prescribed flight path because their directional movements are dictated by the direction of the wind at any given time.

COMMENT: The definition of balloon might be changed so that it includes the fact that a balloon is capable of vertical flight, at times, specifically take-off and landing. However, will this impose any other restrictions?

COMMENT: In the definition of "Balloon" after "engine driven" add "capable of vertical or near vertical flight," because a balloon is non-powered and does not depend on horizontal motion to become airborne. The rate of ascent and descent is controlled by the pilot taking into consideration the winds during launch and landing.

COMMENT: The definition "vertical flight aircraft" seems to be directed toward aircraft such as helicopters, etc., but could be misconstrued to include balloons, which do not have the same capabilities as that type of aircraft. The definition should be modified to read "except balloons."

RESPONSE: The term "vertical flight aircraft" commonly refers to a powered aircraft. To prevent any misunderstanding regarding balloons, the word "powered" is being added to the definition, for purposes of clarification.

N.J.A.C. 16:54-2.1

COMMENT: The horizontal geodetic referencing system used in all charts and chart products published by the National Oceanic and Atmospheric Administration will change from North American data 1927 to North American data 1983. The federal regulations state, "you should become familiar with this congressionally mandated change in advance because it will affect the latitude and longitude coordinates of almost all points identified in the national air space system."

RESPONSE: This is not an issue in the rules; the proper data base will be used as appropriate.

COMMENT: This area can be streamlined considerably. There's too many forms and requirements for each, sometimes requires the same things. The forms can be streamlined considerably and should be implemented into the new regulations.

RESPONSE: The structure of the new forms has been designed to simplify the workload and reduce confusion for the applicants. This streamlining was accomplished as a part of the Department's update of the rules, during which the required forms were reviewed and updated in an effort to minimize the number of forms and any confusion they might cause.

COMMENT: It is proposed that the community and the Office of Aviation and other agencies of the government work together in harmony and try to iron out the problems of planning.

RESPONSE: The Department concurs.

N.J.A.C. 16:54-2.1(a)

COMMENT: The regulations refer to latitude/longitude defined by seconds. Airports are defined by latitude/longitude in degrees, minutes and fractions of a minute.

RESPONSE: The requirement for latitude and longitude should be to the nearest hundredth of a second. The "hundredth of a" was typographically omitted. In addition, the Office will allow the use of minutes and fractions, if they are accurate to ten thousandths of a minute. This allowance has been added and the typographical error corrected.

COMMENT: Specific standards should be set to define routine airport improvements.

RESPONSE: Improvements to airports are considered alterations and are subject to the application process as set forth in N.J.A.C. 16:54-2.

N.J.A.C. 16:54-2.1(a)1iii

COMMENT: This section generally provides that the application shall include "a description of the expected use and activity level of the new or altered facility." In order to permit the NJDOT to really evaluate the application in this regard, this requirement should be spelled out with specificity, i.e., number of anticipated movements; noise exposure map; specification of type of aircraft and aeronautical activities to be conducted; type and frequency of instructional training, etc.

RESPONSE: The rules, as written, provide the Office of Aviation with the ability to request any items, materials, or data, necessary for evaluation of the application, without being restricted to only those items set forth in a list in the rules.

N.J.A.C. 16:54-2.1(a)1iv

COMMENT: This section requires that the application forms for permanent facilities include "a certificate or statement from the applicant that he has advised the appropriate governing body in writing, by personal delivery or certified mail, return receipt requested, of his proposed action, as submitted in the application." Who determines the identity of the appropriate governing body? It is believed that the local municipalities are in a far better position to determine "the appropriate governing body" than the applicant.

RESPONSE: The appropriate governing body is the entity which has ultimate governing responsibility for the political subdivision in which the facility is located. The phrase has been defined in the adopted rules, for clarity. In addition, to ensure adequate dissemination of the information, the applicant is also being required to notify the county in which the facility is to be located.

N.J.A.C. 16:54-2.1(a)2

COMMENT: Balloon ports should only require a sketch and not certified drawings or plans, because of the expense incurred by balloonists.

RESPONSE: In accordance with N.J.A.C. 16:54-2.1(b), a request for waiver of the requirement for certified drawings may be submitted.

N.J.A.C. 16:54-2.1(a)6

COMMENT: This section requires proper notice to be given by the airport when engaging in various activities. The rule should ensure that the local municipality is served with the notice and cannot be bypassed by designating the county as the appropriate government authority to be noticed.

RESPONSE: The rule requires that the notice be submitted to the appropriate governing body for their response, which may be a municipality, county, authority, and/or other agency. The rule does not fix any specific jurisdiction, since this may vary, according to the specific situation.

COMMENT: In addition to providing that the facility must conform with the Uniform Construction Code and Uniform Fire Code, the rules should provide that all appurtenances and activities of the facility comply with State and local fire code requirements and any State and local construction code requirements, as well as FAA requirements.

RESPONSE: In order to facilitate the issuance of the certificate within the allotted time, the requirement, that the certificate issued by the controlling government body certifying that the facility can be constructed in accordance with the Uniform Construction Code and the Uniform Fire Code, is being deleted. Compliance with building and fire codes are matters which should be addressed when building permits are requested. N.J.A.C. 16:54-2.1(a)6 and 7 have been revised to make clear that the Department requires the applicant to show conformance with existing zoning and land use ordinances.

COMMENT: This section provides, "for the purpose of land use and zoning, any aeronautical activity is considered a permitted use at a public use aeronautical facility . . ." There may be environmental, traffic, noise or other concerns of a traditional land use/zoning nature that could make the proposed activity singularly inappropriate. The NJDOT lacks the authority and legislative mandate to intrude upon land use and zoning issues which are within the local municipality's purview.

RESPONSE: The term "permitted use" has been deleted, as part of the deletion of paragraph b, and the concept of conforming use has been added, in order to assure that the applicants follow the guidelines set forth in the land use law. This does not eliminate the need to meet other applicable requirements. The Commissioner of Transportation has the authority to license and locate aeronautical facilities in the State of New Jersey, as long as he or she considers valid expressions of municipal interest. In order to more clearly explain the use provisions, they have been deleted from this section and included in N.J.A.C. 16:54-3.2 and 3.3.

COMMENT: By state law today, airports can't be a nonconforming use. This should be clarified and strengthened, and it needs only be done by the enforcement, by the state, of the current laws as they exist and maybe this area won't even be necessary.

RESPONSE: While public use aeronautical facilities are conforming uses, before the Commissioner sites a new facility, he or she must consider local land use laws, compatibility with surrounding land uses, and expressions of municipal interest. This rule reaffirms that responsibility.

COMMENT: The present regulations do not specifically require that an applicant appear before a local zoning board or a planning board. Our reading of the new regulations indicates that such a requirement will be enforced.

RESPONSE: Although the Commissioner may remand an application to the appropriate governing body, the rules do not require such a step for all applications. The provisions of N.J.A.C. 16:54-2.1(a)6 have been restated to clarify the requirement for municipal input in such matters. This allows the municipalities an opportunity for full input into the process and helps to develop a record concerning the license application.

COMMENT: This section purports to override local laws and use agreements and is inappropriate.

RESPONSE: It is unclear to what sections of the rule the comment refers regarding overriding local laws. Nevertheless, in areas where the State has pre-empted the field, local laws or use agreements which are inconsistent with Federal or State law are invalid; just as State laws which conflict with Federal laws in a pre-empted area are invalid.

COMMENT: The proposed rules unconstitutionally deprive the municipalities in New Jersey of their power and authority over zoning and development. Municipalities would have no power to stop or control airport development, expansion, change in runway direction or the type of aircraft permitted.

RESPONSE: Municipal input is a necessary part of any aeronautical license application and must be considered by the Commissioner before any decision is made. However, the Commissioner's authority over aeronautics in this State is statutorily granted, by N.J.S.A. 6:1-29.

N.J.A.C. 16:54-2.1(a)6i

COMMENT: Local authorities must be afforded the right to process applications consistent with the time periods established by the Municipal Land Use Law, and not merely forty-five days.

COMMENT: The forty-five day deadline is totally inadequate and contrary to the Municipal Land Use Law (N.J.S.A. 40:55D-1 et seq). The deadline should be changed so that it really is consistent with N.J.S.A. 40:55D-1 et seq.

COMMENT: The time period requirement on municipal approval or disapproval of the airport owner applicant for any changes at facilities is favorable. Putting that in a timely fashion is in the best interest of all airport users.

COMMENT: This section requires local government to provide a statement as to land use ordinance compliance or noncompliance within 45 days of the date of application. Due to the nature of local governments not being full-time positions, at least 60-90 days should be allowed.

RESPONSE: The rules are being amended to allow for full compliance with N.J.S.A. 40:55D, as part of the provision of a statement of compliance or noncompliance with land use ordinances. Although this change is being made in order to assist the municipalities in providing a response, it must be noted that the Commissioner, in the placement of aeronautical facilities, is implementing a State statute and is not controlled by the Municipal Land Use Law. The Commissioner will however, continue to give weight to local interests, compatibility of an aeronautical facility with surrounding land uses and local ordinances.

COMMENT: Is the "relevant government authority" different from the "appropriate governing body?"

RESPONSE: The term has been made consistent throughout the chapter as "appropriate governing body."

N.J.A.C. 16:54-2.1(a)10 and (b)

COMMENT: The provision for waivers of application requirements is overly broad and unjustified from the vantage point of protecting the flying public as well as the general public. "Hardship" should not be a reason for noncompliance with licensing application requirements. The "scope and magnitude" exception would deprive the vital content of other provisions of the regulations requiring appropriate licensure applications and evaluations, since it is standardless, vague and undefined.

RESPONSE: Hardship, in a situation where safety is not an issue, is generally considered a valid reason for granting relief from a rule or requirement. The provision for a waiver to application criteria based on scope and magnitude is to eliminate burdensome paperwork when it would be duplicative or outside the focus of the area under consideration. For example, a minor alteration to a facility may contemplate widening of a taxiway. It would be overly burdensome to require the licensee to submit a complete and total facility application package for such work.

N.J.A.C. 16:54-2.1

COMMENT: For Balloonports add the following provisions as subsection N.J.A.C. 16:54-2.1(c):

A. In order to maintain safe operations, auxiliary launch sites may be required. Application for these facilities shall be included as part of the balloonport and shall not require any additional fees provided that they meet with N.J.A.C. 16:54-2.1(c).

B. Occasional launch site will be allowed on a one time basis provided that the balloonport operator has determined that safety can be maintained at that site. There shall be no additional fees for the use of occasional launch sites.

C. Tethered balloon operations shall come under the scope of the balloonport and shall be considered either as an auxiliary launch site or as an occasional launch site as the situation deems appropriate.

All applications for Public Use Balloonports, or for any Balloonport requiring facility modification or preparation, shall meet the requirements of N.J.A.C. 16:54-2.1(a) above.

RESPONSE: Auxiliary sites are currently a provision of the rules. The occasional launch site proposal is covered by the temporary license section of the chapter and does not need to be added. Tethered balloons and their operation are not intended to be covered in this rule because there is no intent for free flight.

N.J.A.C. 16:54-2.2 and 2.3

COMMENT: These entire sections should exclude balloons. Due to the nature of ballooning, balloonists may have many temporary facilities and these would put needless financial burden on the balloonists.

RESPONSE: Balloons are certificated aircraft and, as such, are properly addressed by the provisions of this chapter. The Department believes that the requirements imposed on balloonists by this chapter are not unduly burdensome or restrictive.

N.J.A.C. 16:54-2.3(a)

COMMENT: This section allows for the waiver of public notice. There should not be any waiver of notice allowed, either in this section or any other part of the rules. The airport may not be aware of the local municipality's views concerning particular situations, and do not represent the interests of the local municipality, the residents, or surrounding municipalities. The local municipality must be given notice in all instances so that the rights of the local citizenry are protected or represented.

RESPONSE: The intent is to require that notice be given to the appropriate governing body at all times. Where it is impractical for an applicant to meet the formal public notice provisions, the applicant, at a minimum, shall be required to notify the appropriate governing body. The rule has been clarified to specify that requirement.

N.J.A.C. 16:54-2.3(a)

COMMENT: The text of the legal notice that is to be provided by the Office should be subject to editing so as to have the content of the notice fit the particular circumstance. The notice should be required for all applications and the Office should not have unbridled discretion over when airports let the public know what development projects they are undertaking.

COMMENT: All airport owners must notify not only the State of proposed changes, expansions, etc., but also local governments and residents who will be directly affected by such changes.

RESPONSE: The Department's intent has always been to require notice. For clarity, the wording has been changed to "at a time specified" rather than "when required." In addition, the content of the notice has always been expected to reflect the scope of the specific application. Finally, the publication requirement has been clarified to include the locale of the appropriate governing body.

N.J.A.C. 16:54-2.3(b)

COMMENT: A period of public comment and response of not less than sixty, rather than fifteen days, is much more reasonable.

RESPONSE: The period for public comment has been changed to 30 days to be consistent with the existing Public Notice advertisement requirement, as shown in Appendix A. In addition, the wording has been adjusted to better explain the intent concerning notice requirements for new facilities.

N.J.A.C. 16:54-2.4

COMMENT: Public hearings should be required of all license applications in addition to any local hearing requirements, and most particularly where the NJDOT purports to override specific local land use requirements or master plans.

COMMENT: N.J.A.C. 16:54-2.4(d) says the Commissioner may direct that a public hearing and/or informational meeting be held regarding an application for license. This should read that the Commissioner must direct that a public hearing be held regarding an application for a new license, or alterations, expansion, and relocation of an existing runway.

COMMENT: Public hearing requirements shall be set and should not be discretionary, and include specific instructions that all questions raised at the public hearing be answered prior to any application proceeding.

RESPONSE: The need for a public hearing will be based on the responses to the required public notice. Mandating a public hearing would not, in some instances, be in the public interest. As a result, a public hearing would be convened which would be costly and time consuming, but would serve little purpose. However, in response to these comments, the wording has been modified to give the Commissioner more latitude in ensuring that the public will be heard.

COMMENT: To make the applicant fully responsible for all costs of any hearings and the relevant data and information can be extremely

costly. Since airports are an integral part of the air transportation system, those hearings which provide for improvements which are public use and "non-revenue producing" should be exempt, i.e., runway and taxiway improvements.

RESPONSE: The burden of application fees and associated costs must be borne by the applicant, just as they are for any other type of project. To do otherwise would require the State to subsidize the applicant.

COMMENT: Portions of the regulations compelling an applicant to appear before a local authority should be deleted.

RESPONSE: The requirement that the applicant receive a letter of compliance or non-compliance does not, in and of itself, require an appearance before the appropriate governing body.

COMMENT: Public notice requirements and public hearing provisions should also comply with the procedures, time limits, and public comment requirements for the Municipal Land Use Law.

RESPONSE: The Commissioner, in licensing aeronautical facilities, is acting pursuant to a State statute which grants him or her ultimate authority in the area, and, therefore is not controlled by the Municipal Land Use Law, N.J.S.A. 40:55D. The Commissioner will, however, always undertake to obtain and consider input from the appropriate governing bodies.

N.J.A.C. 16:54-2.5

COMMENT: The proposed rules provide the mechanism to improve relations between airports and their host communities.

COMMENT: A dispute resolution process should be established by the NJDOT in order to attempt to resolve conflicts between airport facilities and the communities in which they operate.

COMMENT: The proposition that NJDOT will assume new responsibility in the airports' relationship with the community assumes, of course, that the NJDOT in an even handed way will judge what is best for the community. It is difficult to believe that NJDOT will represent the non-flying property owners in the vicinity. Locally elected representatives are our best protection against our loss of property value.

RESPONSE: It is the intent of these rules to facilitate improved relations between aeronautical facilities and local governing bodies and communities and to provide for local input into the licensing process, as provided in N.J.A.C. 16:54-2.3, 2.4, 2.8 and other sections.

COMMENT: An environmental impact statement should be required for all airport improvements.

RESPONSE: Not all airport improvements require environmental impact or environmental assessment statements; however, where required by law, environmental impacts and assessments will be required.

COMMENT: Exception is taken to the statement that the ultimate authority for environmental impact, including airport noise, lies with the Commissioner.

RESPONSE: The rules do not assert that the Commissioner has the ultimate authority for environmental impact in this State.

COMMENT: This proposal basically is going to put the power from the state to the airports. It's going to end up being the state against the municipality.

RESPONSE: The rules reflect the authority vested in the Commissioner, by statute, to license and regulate aeronautical facilities. This power will not be transferred to airports.

COMMENT: Any kind of municipal constraints that a municipality would like to put on an airport should have the concurrence of the Director of the Office of Aviation before it can be enforced.

RESPONSE: A valid exercise of municipal authority that does not intrude into areas preempted by the State or Federal government would not require the concurrence of the Director.

COMMENT: In addition to requiring an applicant to make application to the local authorities, the proposed regulations further provide that the Commissioner may require an applicant to appear at a public hearing and/or informational meeting. It is believed that the two-tiered hearing procedure set forth, in addition to being duplicative, expensive and time consuming, will violate the spirit of the Aviation Act.

RESPONSE: This is not meant to be duplicative. Making application to the appropriate governing body may resolve issues, thereby eliminating any need for a public hearing. When it does not, a public hearing may be appropriate.

COMMENT: Generally opposed to the procedure and regulatory content of the proposed rules, because it adversely affects the environment and quality of life of most persons in this state.

RESPONSE: These rules are designed to promote safety and to effectively regulate the licensing of aeronautical facilities in the State of New Jersey. When aviation is a properly integrated mode of transportation, it does not adversely affect the environment and, in fact, enhances the quality of life for both economic and social reasons.

COMMENT: We are very mush interested in being afforded an opportunity to work with the New Jersey Office of Aviation, airport owners and managers, city and county officials, airport users, and interested citizens in preserving the utility of New Jersey airports and insuring that they continue to be good neighbors. We are confident that legitimate concerns about airport operations and safety can best be addressed with the input of all concerned parties working together. More and tougher regulations, however, don't necessarily insure a better or safer aeronautical facility.

RESPONSE: Noted.

COMMENT: The Department is to be commended for providing that "Factors such as surrounding land uses, local zoning ordinances, topography, noise characteristics of the type of aeronautical equipment to be used, air traffic patterns proposed in the area, and any other relevant information shall be part of the consideration required for such license processing." Realistically, however, how does the Department propose to obtain meaningful input and understanding of those factors? Without routine notice to the public and without serious consultation with the municipality, little more than lip service will be paid to those factors. A process must be established to ensure that the Department is provided with information relevant to the enumerated factors.

RESPONSE: The applicant is required to notify the appropriate governing body of their applications. Any issues raised by them, or by the public, will be evaluated and made a part of the Department's consideration of the application.

COMMENT: The factors considered do not include any aeronautical operations or demand data, nor do they analyze the economic impact of the facility.

RESPONSE: These factors will be considered and they have been added to N.J.A.C. 16:54-2.5(a).

COMMENT: Any application approval should contain, as express conditions, relevant factors critical to the Department's approval, including the specific factors evaluated in connection with the requirements of N.J.A.C. 16:54-2.5.

RESPONSE: Where necessary, express conditions of licensure are presently a common practice, when such conditions are relevant to the operation of the facility.

COMMENT: We are opposed to the part of the regulations which would give municipalities a vote to the licensing and regulation of airports.

RESPONSE: The rules do not provide municipalities a vote in licensing airports. However, municipal concern and input are legitimate factors in such matters and will be fully considered by the Commissioner.

N.J.A.C. 16:54-2.6

COMMENT: We are strongly opposed to the provision which states "the governing municipal body must be afforded the ability to approve applications for facility changes just as they are afforded that ability for initial applications."

RESPONSE: N.J.A.C. 16:54 does not contain such a provision.

N.J.A.C. 16:54-2.7

COMMENT: Approval by local authorities, as well as the FAA (where applicable), should also be required.

RESPONSE: Where appropriate, input from local authorities and FAA is obtained and considered before any notice to proceed is given. No applicant may proceed with any construction, modification, or closure until he receives written approval from the Director.

N.J.A.C. 16:54-2.8

COMMENT: The regulations should be clarified to require (a) public notice in all instances of license renewal applications, and (b) certification such as that required by [N.J.A.C.] 16:54-2.1(a)6 that the facility remains in conformance with applicable ordinances.

COMMENT: In the event of complaints of violations, a public hearing should be required in connection with license renewal.

COMMENT: All considerations applicable to the initial license application and approval should apply to renewals.

COMMENT: Procedural guidelines should be set for the review of renewal applications for existing facilities.

RESPONSE: Renewal is based on the licensee conforming to the standards set forth in this chapter. Requiring a licensee to meet all initial application requirements annually is overly burdensome and duplicative.

However, for public use aeronautical facilities, the appropriate governing body will be notified by the Office of the intent to renew the license.

COMMENT: Recommend that all licenses for State Police facilities issued by the Department have no expiration date, until such time [as the] proposed regulations are adopted.

RESPONSE: The requirement for license expiration is set forth in statute, at N.J.S.A. 6:1-44.

N.J.A.C. 16:54-2.9

COMMENT: The transfer of a license should require a notice to the affected municipality and municipal approval.

RESPONSE: The suggestion regarding notice is being accepted and a copy of the licensee's letter of intent will be sent by the licensee to the controlling govering body. Approval of any transfer is a responsibility that rests with the Commissioner.

N.J.A.C. 16:54-2.10(a)4

COMMENT: It is unclear what will determine the applicability of the detailed plan that will be required to satisfy the provisions of N.J.S.A. 6:1-94(c). Reference should be considered that, when applicable, the Office will review the requirements with the licensee and communicate those requirements to the licensee.

RESPONSE: These provisions apply only to public use airports which have received Airport Safety Fund grants. Details of the requirements are spelled out in the grant agreement with a particular airport.

N.J.A.C. 16:54-3.1

COMMENT: This section should contain the language depicted in N.J.A.C. 16:54-1.4, paragraph 8(b), Supplement 1-17-89, Page 54-10, and also expanded to include any alterations, improvements, or additions to existing airports and runways.

RESPONSE: The recommended language exists in N.J.A.C. 16:54-2.5(a).

N.J.A.C. 16:54-3.1(a)

COMMENT: The State and FAA must continue to strengthen their pre-emptive authority. It is hoped that the new rules will make it easier for airports to operate and create an environment where aviation facilities can grow and prosper as an industry and vital link in New Jersey's overall transportation system.

COMMENT: This section should include any regulations, or ordinances set by the local government which would be instituted by the people living near the airport and are the ones most directly affected by its everyday operation.

RESPONSE: The regulation of aeronautical facilities and their oeprations rests with Federal and State governments which have pre-empted the field. Any municipal ordinances which do not apply to the regulation and control of an aeronautical facility are within the purview of the appropriate governing body, but are not appropriate for inclusion in these regulations.

N.J.A.C. 16:54-3.1(b)

COMMENT: In addition to the general standard of "safe and hazard-free condition," more specific standards making this less vague should be spelled out or incorporated by reference.

RESPONSE: Facility standards, if not fully set forth herein, are, where appropriate, incorporated by reference to relevant FAA standards, regulations or advisory circulars.

N.J.A.C. 16:54-3.1(c)

COMMENT: This section addresses inadvertent entry by unauthorized persons to aeronautical operating areas of airports. The regulation as written provides the Commissioner with the discretion to decide what measures adequately address inadvertent entry, and to enact severe or cost prohibitive measures that could adversely affect the airport.

COMMENT: Strongly oppose to the requirements that operators provide acceptable safeguards against inadvertent entry. Most small public use, privately owned airfields are not presently fenced from the general public. The cost of providing adequate fencing and security at these facilities would be prohibitive.

RESPONSE: The Commissioner of Transportation is charged with the responsibility to ensure the safety of the general public and those participating in aeronautical activities. This rule allows the Commissioner to use his or her discretion, rather than specifying a single standard, which may be excessive.

COMMENT: If fencing or barriers are being implied, balloon launch fields should be excluded.

COMMENT: Removal of the requirement for fencing is a very positive thing based on FAA research work dealing with helicopter accidents.

COMMENT: The regulations state "to provide safeguards acceptable to the office to prevent inadvertent entry to the aeronautical facility," this could be very bewildering depending on how it is enforced.

COMMENT: Clarification should be made on exactly what safeguards on an airport or encroachment by the public to airport activity areas means.

RESPONSE: "Adequate safeguards" do not necessarily mean fencing. The need to "maintain adequate safeguards" protects the public as well as the users of the facility. The specific safeguards would certainly vary facility by facility and could be signs, markers, fencing or other items, depending on the complexity of the facility. The Office of Aviation will work with facility owners to determine what is adequate for their specific aeronautical facility.

COMMENT: This section should also indicate that at public use aeronautical facilities, anyone, provided he/she does not interfere with the facilities operations, should be permitted to enter the non-aircraft operating area of the premises.

RESPONSE: The aeronautical facility's rules and operating regulations will address this issue. They may vary, facility by facility, and therefore are not mandated by the Office as a single standard.

N.J.A.C. 16:54-3.1(d)

COMMENT: This section specifies that any aircraft technically capable of landing at a given aeronautical facility must be permitted to use that facility. This provision contradicts law established by *Garden State Farms, Inc. v. Mayor Louis Bay, II,* 77 *N.J.* 439 (1978), which held that the Commissioner must consider "all important legitimate local government interest" when supervising and regulating aeronautical activities.

RESPONSE: The State is preempted by Federal law in this area. N.J.A.C. 16:54-3.1(d) recognizes the Federal mandate which prohibits public use aeronautical facilities from discriminatorily preventing the operation of such aircraft. The Department recognizes that agreements may be made between licensees and others regarding certain activities or operations. In order to assure that such agreements are known to the Department and to the public, a requirement to include such provisions in the Facility Management Standards and General Operating Rules has been added at N.J.A.C. 16:54-3.1(d).

N.J.A.C. 16:54-3.1(f)

COMMENT: "To inspect all records." Only those records pertinent to the issues of viability of the operations should be available. Unless there are specific state regulations regarding ethics and conflict of interest, there is nothing to stop a State Official from inspecting these records and using for personal gain when leaving the Office of Aviation. Also, inspections are covered in two separate parts of the regulations which creates confusion.

RESPONSE: The wording has been clarified to "all records related to the aeronautical facility." Stringent ethics laws and Department rules exist and are enforced to prevent a situation such as described by the commenter. The inspection provisions have been incorporated in a single area under the general provisions to eliminate any confusion.

N.J.A.C. 16:54-3.1(g)

COMMENT: The provisions of this section would be inappropriate for balloonists since there are rarely any buildings on the launch site.

RESPONSE: For various types of facilities, the "premises" requirement may not be possible to meet. In such circumstances, the licensee will be permitted to have the license available at the office or residence of the licensee. This allowance will be made on a case-by-case basis as a waiver to the requirement. In this way, the Office will know where each license is posted.

N.J.A.C. 16:54-3.1(i)

COMMENT: This section should be amended so as to only refer to multiple suspensions of previous aeronautical licenses. The FAA has recognized that this type of criminal limitation lacks necessity and effectiveness and is objectionable, due to its intrusiveness and civil rights concerns.

COMMENT: The provisions that "Licensees shall not be convicted felons or have multiple suspensions of previous aeronautical licenses" is insufficient to protect the public interest. First, a definition should be provided of "operator" such that anyone playing a substantial part in the operation or management of the facility and anyone with an ownership interest is subject to this stricture. Second, in some circum-

stances, evidence of a serious infraction, whether or not even a single suspension resulted, should be possible grounds for revocation or denial of a license consistent with any due process requirements. Certainly, multiple suspension should not be a necessary prerequisite. Third, the NJDOT should be required to investigate the applicant or license holder and he/she should be required to supply such relevant information (including youthful conviction records) if the provisions are to have any meaning at all and so the public can be protected.

RESPONSE: Upon further review of this provision, it has been determined that, as written, it is overly broad. In light of this, the provision has been amended to remove the reference to convicted felons.

These rules pertain to the licensing of an aeronautical facility and the licensees thereof. To attempt to expand the criteria to apply to others is inappropriate. Therefore, the suggested definition of operator has not been accepted by the Department.

The criteria upon which licensure is based must be reasonable and just. Therefore, specific criteria must be available to make such a determination, which determination should be based on due process. The provisions for suspension of licensure meet these qualifications, while evidence of an infraction, without recourse, does not. The basis for qualification for licensure cannot, therefore, be expanded as the commentor proposes.

The commentor asks that DOT be required to investigate the applicant or licensee. Except in certain very specific and restricted circumstances, background investigations cannot be done by the NJDOT. Therefore, the commentor's recommendation cannot be implemented.

N.J.A.C. 16:54-3.1(j)

COMMENT: The phraseology "shall be residents of New Jersey or" should be deleted. It is not considered necessary and is overly burdensome for corporations.

RESPONSE: The residence or agent requirement is mandated by statute (N.J.S.A. 14A:2-7). The wording of the rule, however, has been adjusted to track the wording of the statute exactly. The requirement that corporations be resident or have an authorized agent has been expanded to include corporations registered to do business in New Jersey. This expansion eases the burden or corporations which are registered in the State, in that they are no longer required to have an agent.

N.J.A.C. 16:54-3.1(k)

COMMENT: There are no standards set forth in the regulations for determining the distance of such "building restriction line." This could be established arbitrarily by the Commissioner, without consideration of land ownership and uses, with the result that adjacent property owners will demand compensation for unlawful takings.

RESPONSE: Building restriction line standards are established by the FAA as requirements to maintain adequate runway-to-building separation for operational safety. Therefore, FAA Advisory Circulars 150/5300-12 and 150/5300-13 are applicable, as they set forth those standards. (See N.J.A.C. 16:54-4.2(a)1i, ii and iii.)

COMMENT: A word should be added that after a specific date no building should be required or allowed within the building restriction lines and the runway.

RESPONSE: Any penetration to the building restriction line criteria must be reviewed and evaluated on a case-by-case basis.

N.J.A.C. 16:54-3.2

COMMENT: This Section addresses general requirements for all public use aeronautical facilities, including written aeronautical activity standards. On publicly funded airports, recommend that those approved activity standards be reasonable, relevant, and not unjustly discriminatory. Provisions for full and limited activities should be addressed and encouraged; however monopolistic commercial aeronautical activities should be discouraged.

COMMENT: The proposed regulations require written procedures concerning flight instruction. Does that mean our curriculum is going to be subject to regulation? Is the state trying to permit or deny the activity?

RESPONSE: The term "Aeronautical Activity Standard" has been misinterpreted by a number of commenters. The intent is to establish a set of guidelines which the licensee would use for the oversight of aeronautical activities which are conducted at their facility. To prevent further misunderstanding, the term Aeronautical Activity Standard is being changed to Facility Management Standard.

COMMENT: The licensing rules will impose an unnecessary burden of paperwork and additional expense that will adversely affect the operation of what is essentially a public service helicopter utilizing a Special Landing Strip Certificate and Official Use Helistops to conduct public service and public safety missions.

RESPONSE: Waivers of licensing provisions may be requested. However, the requirements set forth in the rules have been designed not to require any significant expense or burdensome paperwork.

N.J.A.C. 16:54-3.2(b)

COMMENT: The written Aeronautical Activity Standards for all aeronautical activities should be standardized by the Office in such a way as to minimize the confusion, variation and time spent to produce the document as well as to improve and simplify the review, edit and approval of the document by the Office. It could, for the most part, be formatted to simplify its completion by the licensee.

RESPONSE: Facility Management Standards will necessarily vary from aeronautical facility to aeronautical facility and from operator to operator. The intent is to ensure that each airport provides safe facilities and adequately manages or oversees the activities conducted at that aeronautical facility. The Department will review and approve these standards on a case-by-case basis. Where activities at different aeronautical facilities are the same, the Office encourages standardization, where appropriate.

COMMENT: The section on aeronautical activity standards is very confusing and seems to jump around making it difficult to comply with its provisions.

RESPONSE: In order to simplify and clarify this section, it has been restructured. The content remains the same; the format has been modified for ease of reading.

COMMENT: This section greatly expands the definition for "aeronautical activities" to include "any activity specifically approved by the Commissioner." Other portions of the regulations imply that any use, regardless of impact upon the public, could be approved by the Commissioner. There are no standards for such decisions, nor are there any requirements for municipal comment or approval.

RESPONSE: The definition of aeronautical activity was never intended to be an all inclusive "any use," as suggested by the Commenter. Its intent was to articulate the areas contemplated by N.J.S.A. 6:1-29 et seq. However, in light of the number of strong concerns expressed which indicates that this area may have been misinterpreted, the Department is deleting N.J.A.C. 16:54-3.2(a)5 and are including the list of activities in the definition of "aeronautical activity."

COMMENT: Can facilities licensed under the present rules be exempted from the more expensive requirements of the regulations?

RESPONSE: While safety considerations are paramount and cannot be waived, applicants can petition for waivers or exemptions of non-safety items, based on the criteria outlined in subchapter 7.

COMMENT: The state should develop a standard format for Aeronautical Activities Standards in every airport in New Jersey to follow.

RESPONSE: The Office of Aviation will make available a sample format, in outline form, which may be used as a guide in preparing the required manuals. However, the requirement to prepare such manuals within the allotted time rests with the licensee.

N.J.A.C. 16:54-3.2(c)

COMMENT: Aeronautical activities standards should be available to any person who wishes to obtain a copy. Availability should not be limited to tenants and persons engaged in aeronautical activities or users of the facility.

RESPONSE: The document is to be posted for review. There is no limitation nor restriction on availability of these documents.

N.J.A.C. 16:54-3.2(f)

COMMENT: General operating rules should be available to any person who wishes to obtain a copy. Availability should not be limited to tenants and persons engaged in aeronautical activities or users of the facility.

RESPONSE: The rules must be posted and available for review. There is no limitation nor restriction on the availability of these documents.

COMMENT: This section requires that the licensee establish written aeronautical facility General Operating Rules to ensure public safety. These rules should include specific instructions concerning traffic patterns and noise abatement.

RESPONSE: Traffic patterns, and noise abatement procedures where applicable, shall be included in the facility's General Operating Rules.

N.J.A.C. 16:54-3.2(g)

COMMENT: Availability of a public phone is certainly a convenience and a good idea from a safety viewpoint. However, this provision should not be required at limited use facilities, such as those identified State Airport System Plan (SASP) tier 4.

RESPONSE: There is no requirement for a public telephone per se. The requirement is for communications with FAA and in the event of an emergency. This is a safety requirement and must be available at all public use facilities.

N.J.A.C. 16:54-3.3(b)

COMMENT: This seems reasonable since the owner of a restricted use landing facility would owe a duty to a prospective user to brief him on any unusual conditions to be encountered at the airport. However, [subsection] (c) contradicts [subsection] (b) by requiring a written request to be filed with the Office and an appropriate concurrence obtained. This certainly is not the same or as easy as merely securing permission from the airport owner. The owner/operator is in a better position to assess local conditions and can better brief prospective airport users.

RESPONSE: The requirement in subsection (c) is for a person who wishes to conduct an aeronautical activity at the facility. To ensure clarity, N.J.A.C. 16:54-3.3(b) has been expanded to include aircraft operations into and out of the facility.

N.J.A.C. 16:54-3.3(d)

COMMENT: Does the paragraph require the licensee to specifically include balloons on his license?

RESPONSE: Any type of aeronautical activity, including commercial balloon activities conducted at that facility, must be addressed by the licensee in meeting this provision of the rule. Balloon takeoffs, however, are no different from takeoffs of any other types of aircraft and must meet the same requirements as for those other aircraft.

N.J.A.C. 16:54-3.4(a)

COMMENT: Does this section require that each pilot be named, as in a partnership, or that each aircraft be listed?

RESPONSE: Both items are required. To ensure clarity regarding the aircraft, the rule now states, "only those aircraft specifically designated on the license and meeting minimum FAA certificated aircraft operating performance manual standards and limitations."

N.J.A.C. 16:54-3.4(b)

COMMENT: A minimum requirement that users of Special use facilities hold at least a private pilot's license is excessive. Any and all conditions and regulations specifying minimum licensing requirements should be preempted by the FAA and not invaded by either state or local government regulations.

COMMENT: Regarding the listed operations of special use facilities, student pilots qualified for solo flight should be allowed to use any aviation facility with the approval of their flight instructor. An instructor can make a better evaluation of the relative safety of a flying site and a student's capabilities than the State.

RESPONSE: The requirement for a private pilot's license has been removed from N.J.A.C. 16:54-3.4(b). To clarify this rule, the adopted provisions of N.J.A.C. 16:54-4.4(b) and (c) have been added and N.J.A.C. 16:54-3.4(c) has been recodified to 3.4(b) and clarified. To insure that safety concerns can be met, a requirement to demonstrate the capability to operate at a special use aeronautical facilty has been added to N.J.A.C. 16:54-4.4(b) and (c). In lieu of a specific license requirement, the Department has added the provision that proposed users of an airport demonstrate their ability to operate in a space of like dimensions.

N.J.A.C. 16:54-3.4(e)

COMMENT: Balloons are unique in that their path of flight is determined by their point of origin, and it is highly important to the safe outcome of every flight that the pilot selects a takeoff location that will take the balloon toward suitable areas. The proposed rules would limit a balloonist's choice to those sites approved by the Office of Aviation.

COMMENT: The provisions for auxiliary sites with special use facilities should also be made for restricted use and temporary facilities at least for balloons.

RESPONSE: The commenter makes a valid point for balloonports, since their launch site is wind-dependent. Therefore, N.J.A.C. 16:54-3.3 and 6.3 are being expanded to include this provision for auxiliary sites.

N.J.A.C. 16:54-4.1

COMMENT: Why should additional expense to modify existing heliports to meet these criteria be necessary, especially in light of the enviable safety record of New Jersey helistops?

RESPONSE: The Department agrees with the commenter that New Jersey has an enviable safety record. It is the intention of these rules to ensure that the record remains intact. Therefore, in instances where the public safety is involved, and where improvements are required, the expenditure of additional funds may be necessary to comply with these safety mandates.

COMMENT: Is it possible to amend the subchapter to exclude existing helistops without the proposed waiver requirement?

COMMENT: A grandfather clause should be included for design criteria to exempt existing facilities which do not meet such new criteria.

RESPONSE: Any nonconformance with the rules must follow the waiver process to provide the Office the opportunity to independently determine the compatibility of equipment and facilities.

N.J.A.C. 16:54-4.1

COMMENT: What is the disposition of existing helistops if dimensional size cannot be enlarged because of area limitations or construction expense?

RESPONSE: If the helistop cannot be enlarged, it is the responsibility of the licensee to ensure that only equipment compatible with that size facility will be authorized to use that facility.

COMMENT: Would it be possible to include a portion of takeoff and landing zones and factor the area into the dimensional size of the helistop?

RESPONSE: No, the areas cannot be overlapped because safety could be jeopardized. This requirment ensures that adequate area is available for safety of all operations.

COMMENT: Would additional restrictions, i.e., aircraft movement, time, routes and deviation reporting be removed when all criteria are satisfied at existing helistops?

RESPONSE: Restrictions not related to dimensional or design criteria will continue to be applicable.

COMMENT: Compliance with the heliport advisory circular from the FAA is very commendable, however a case-by-case basis should be taken with flexibility on existing facilities. There should be flexibility allowed for grandfathering of certain facilities without a severe compromise of standards.

RESPONSE: Waivers or exemptions may be requested on a case-by-case basis for existing facilities which do not meet current design criteria.

N.J.A.C. 16:54-4.2

COMMENT: If 1,000 feet of clear zone is needed to operate an aircraft safely, this clear zone on each end of a runway should be part of airport property. Runway standards should include at least a 1,000 foot setback from neighboring property lines. If this property is not available on existing airport property, the owner should be required to provide such clear zone setback by purchase through normal business negotiations, or by relocating its runway to meet the 1,000 foot requirement.

RESPONSE: The rule does not require 1,000 feet of clear zone for an aircraft to operate safely. These zones are established and maintained for obstruction clearance purposes and they vary in size, depending on the type and use of the facility. The references to FAR Part 77, N.J.A.C. 16:62 and FAA Advisory Circular 150/5300-13 are included to ensure that applicants, in designing their facility, include appropriate obstacle-free aircraft operating areas. Control of lands within these zones through ownership, easement, or rights is encouraged, but is not mandated by this chapter.

N.J.A.C. 16:54-4.2(a)1iii

COMMENT: Federal criteria are defined in FAA AC 150/5300-13, as revised. The minimum approach slopes and other standards identified are often hard, if not impossible to meet since many airport operators have little to no control over adjacent land uses. In the case of Federal criteria, FAA has the discretion to waive or amend compliance with certain standards, as conditions warrant. However, in the adoption of Federal standards, there are no waiver provisions. Additionally, most state airports not eligible to participate in the FAA Airport Improvement Program (AIP) would have little to no external funding mechanism to help facilitate compliance.

RESPONSE: State standards, even those based on Federal criteria, may be waivable under the provisions of N.J.A.C. 16:54-7. Airports which

have accepted Federal grants are subject directly to Federal criteria and cannot have those criteria waived by the State. Such waivers must be granted by the FAA.

N.J.A.C. 16:54-4.2(a)1iv

COMMENT: This section requires operational lighting systems consistent with the Federal standards contained in FAA AC 150/5340-2 as amended, as a minimum. Without AIP eligibility and/or state financial assistance, compliance in many instances may be impossible.

COMMENT: The statement on the runway lighting reads, "shall be not more than 200 feet apart". The FAA approved other distances even for instrument and night approaches.

RESPONSE: These standards, as developed, have been set to ensure the adequacy of a safe and effective lighting system. While there are costs involved, the safety of the flying public must override that consideration.

COMMENT: There is an issue with the minimum size of a 100 by 100 foot or 100 feet in diameter, exclusive of safety areas, for public use heliports. If you take the FAA criteria for a Ranger 206 L which is representative of the turbine helicopters and use that as a criteria, you need a 74 by 74 foot area. And what happens, 100 by 100 foot is actually larger than the area you need for an S76 which is the largest corporate helicopter in the area.

RESPONSE: The rules as presently drafted assure an adequate safety margin at all public use facilities, and, therefore, have not been amended.

N.J.A.C. 16:54-4.2(a)4

COMMENT: Recommend that the term "Public use balloonports" be changed to "Balloonport shall be not less than 100' × 100' and add "on the down wind side" after 1:1 slope ratio".

RESPONSE: The rules as presently drafted assure an adequate safety margin at all public use facilities, and, therefore, have not been changed.

N.J.A.C. 16:54-4.3(a)

COMMENT: This section requires restricted use heliports to have the same requirement as public use heliports. Nearly all the existing restricted use heliports have been designed and constructed with takeoff and landing area well under 100 × 100 feet, for a single, small helicopter requiring the takeoff and landing areas to range from 60 × 60 to 80 × 80 feet, based on FAA standards. To require these facilities be enlarged unnecessarily will be extremely burdensome to the industry.

COMMENT: It is absurd to require a private airstrip to be designed the same as big airports like Morristown Airport. You are putting all of us out of business.

COMMENT: Balloon ports cannot be held to meet the stringent requirements set for public use facilities.

COMMENT: The 100 × 100 proposed requirement for restricted use heliports should be removed. If not, all existing restricted use heliports should be grandfathered, provided they do, in fact, meet the minimum standards in the FAA Advisory Circular—Heliport Design Guide, AC 150/5390-2.

RESPONSE: Commenters pointed out that requiring restricted and special use facilities to meet the same stringent standards as set for public use facilities is burdensome. The Department, when it included in the proposal, at N.J.A.C. 16:54-4.3, the requirement that FAA guidelines be followed for restricted use facilities, and at N.J.A.C. 16:54-4.4, that FAA guidelines be followed for special use facilities, intended that lesser requirements be applied to such facilities than are applied to public use facilities. The comments have merit, and upon review, the requirements for restricted use and special use facilities have been expanded to reflect the differences. Additionally, a typographical error has been corrected, changing FAA Advisory Circular from 150/5340-2 to 150/5390-2.

N.J.A.C. 16:54-5.1

COMMENT: The rules do not take into consideration different types of public use facilities and aircraft that exist in New Jersey. The rules should reflect that the potential hazard and cost of meeting regulations is all relative to the size of the facility. At limited SASP Tier 4 facilities, many of the proposed rules are burdensome to the individuals who allow public use of their airports.

COMMENT: There is no appreciation in these rules for how aviation is performed at the grassroots level. At the grassroots is where commercial and military pilots in the future are going to come from.

RESPONSE: The rules were carefully prepared to ensure they fully considered all types of facilities and all levels of operation. They are intended to be as unobtrusive as possible. However, every facility must maintain a standard which ensures the safety of all users. These rules reflect those standards.

COMMENT: The regulations do not adequately address ultralight aircraft operations.

RESPONSE: These rules pertain to aeronautical facility licensing and do not address ultralight aircraft operations at all. Ultralight operations are activities regulated specifically by the FAA.

N.J.A.C. 16:54-5.1(a)

COMMENT: The facility operations manual should be made readily available to all users of the facility and to the local governing body.

RESPONSE: The information and material required by the public is provided in the facility's General Operating Rules, as provided for in N.J.A.C. 16:54-3.2(a). The facility operations manual is an internal document which sets forth how the facility will be operated.

COMMENT: The facility operations manual should also be standardized, since much of the information can be formatted. Thus, the licensee, user, as well as the Office will be able to optimize their respective use with a minimal inconvenience and waste of time.

RESPONSE: The Office will make available a sample format, in outline form, which may be used as a guide in preparing the required manuals. However, the requirement to prepare such manuals within the allotted time rests with the licensee.

COMMENT: The facility operations manual should contain specific instructions concerning traffic patterns and noise abatement.

RESPONSE: Traffic patterns, and noise abatement procedures where applicable, shall be included in the facility's operations manual.

COMMENT: The subject of the operation manual appears to have good intentions. However, as written in these regulations, it will be a nightmare for the Office of Aviation, as well as for the airport owners.

RESPONSE: The requirement for a manual has been a concern of several commenters. It is not meant to be a burdensome document. For smaller facilities, it is envisioned that the necessary information can be made available with a minimum of effort.

COMMENT: A very positive requirement is the manual and the emergency awareness that is going to be brought to each one of the heliport operators as to what they would do in case of emergencies.

RESPONSE: This heightened awareness was a part of the intent of the requirement.

COMMENT: It is incumbent upon the Office of Aviation to write a generic manual for the adaptation by the local operators. In this way the state will have a very similar manual to approve, thereby facilities approval by a step, particularly during the current conditions of the Office of Aviation and its limited personnel. It is strongly urged that the Office apply for an FAA grant to fund this endeavor.

RESPONSE: The Office of Aviation will work with aeronautical facilities in preparing their manuals. However, the primary responsibility for the development of the manual rests with the licensee or applicant. The Department will pursue the recommendation to apply for an FAA grant for this purpose.

COMMENT: I recommend that any operations which are required to have an FAA approved operations manual be exempt from this requirement for an operations manual.

RESPONSE: An FAA approved operations manual may be used as the basis for this requirement. State requirements which are not included in that document will have to be added to satisfy the requirements of this chapter.

COMMENT: Balloonports and auxiliary fields should be relieved of most of the stringent requirements of Subchapter 5. The support facilities for power aircraft are much more complex. A balloon by nature is compact and easily transported.

RESPONSE: There is no reason to relieve any category of facility from the requirements of this chapter. Where an applicant or licensee believes an area is not applicable, the applicant or licensee may bring this to the attention of the Office, and apply for a waiver.

COMMENT: The licensee should be required to report all complaints of legal, regulatory and permit violations to the Department in writing.

RESPONSE: Although the comment is unclear as to the type of violations being discussed, it is anticipated that the licensee will make provisions in the Facility Operations Manual to adequately handle such violations. The Office will have oversight of that manual.

N.J.A.C. 16:54-5.1(a)7i

COMMENT: A section of this area now reads that "flying in New Jersey as a student pilot is prohibited."

COMMENT: The limitations imposed by the operational standards regarding minimum pilot standards should be removed to bar any misinterpretation of the rules.

RESPONSE: This was a typographical error and was corrected and relocated to its proper position in N.J.A.C. 16:54-6.5(c)1.

COMMENT: A student pilot certificate is not an acceptable minimum airman qualification is overly restrictive for balloonists since the FAA allows balloon operations with student licenses which are equivalent to private license privileges of other categories.

RESPONSE: The rules have been clarified to recognize the FAA's licensing privileges for balloonists and are now consistent with them.

N.J.A.C. 16:54-5.1(a)7ii

COMMENT: This section creates a condition that only a commercial pilot certificate is acceptable. "For demonstration of exhibition use of a facility ... and." is too restrictive. This language precludes qualified private pilots from participating in charitable fund raising passenger ride events allowed by FAA FAR Part 61.118(d).

COMMENT: For demonstration or exhibition use of a facility, an applicable FAA commercial pilot certificate is the minimum acceptable airman qualification; and this line should be changed to allow private pilot certificates in the case of balloon operations.

COMMENT: Recommend that after the words "airman qualification" add "private pilot balloon not for hire or compensation at balloon events or exhibitions."

RESPONSE: FAA licensing privileges for balloonists and those participating in charitable events are recognized, and, in accordance with FAR 61.118(d), the Office has clarified the rule to reflect those provisions. This section was typographically misplaced and has been relocated to N.J.A.C. 16:54-6.5(c).

N.J.A.C. 16:54-5.1(c)

COMMENT: To report accidents to the local police is understandable, however, to report incidents to local police is unnecessary and burdensome, when the incident could be as minimal as a flat tire upon landing, or an airplane taxiing into the wingtip of another airplane.

COMMENT: It is impossible for a licensee to know about all accidents or incidents which occur off the facility.

COMMENT: "Incidents" should be properly defined. "Contiguous" fails to define the proper scope of this provision so that the Department and other relevant regulatory agencies can appropriately monitor safety issues as they arise. Accidents and other occurrences within an appropriate radius should be reported (for example, within two miles, or if the aircraft was attempting or actually taking off or landing from the airport or intended to do so). This information should be made available by the airport operation and/or the Department upon request by the local governing body or a member of the general public.

RESPONSE: In light of the comments regarding the reporting requirements, these provisions have been reviewed and the reporting provisions have been clarified to make compliance with the regulation less burdensome. In doing so, the terms "accident" and "incident" have been defined and the provisions of N.J.A.C. 16:54-5.1(c) have been clarified.

N.J.A.C. 16:54-5.1(d)

COMMENT: Only the FAA may promulgate rules that govern airspace.

COMMENT: The rules should provide that if there is a duly promulgated recommendation of the logal governing body of the relevant impacted legal subdivision(s) regarding flight patterns, that it will be adopted, absent a showing of countervailing safety concerns, if any, to the duly elected representatives of the locality and remove the licensee and the Department from any competing local interest disputes.

RESPONSE: The Department's rules have always accepted the fact that the FAA preempts the area in regard to airspace management. The Federal regulations do not prohibit State involvement. N.J.A.C. 16:54-5.1(d) and (e) have been clarified to better show the inter-relationship between the State and Federal regulations.

COMMENT: Considerations for land use of the newly affected area under the proposed flight path must be studied with respect to densities, residential and public (schools, etc.). This must be a criteria when designing flight patterns and not simply which direction affords the longest possible runway.

RESPONSE: These criteria have always been considered valid factors to be weighed in determining air traffic flight patterns. It is the intent of the office to entertain valid expressions of municipal concern when reviewing proposed changes to air traffic flight patterns.

COMMENT: It would appear that proposed changes to air traffic patterns need FAA approval before implementation. Should FAA approval be received and the Office has not approved such change, it would appear the licensee can implement such change. The proposed language is in conflict with that authorization.

RESPONSE: The language has been clarified to set forth the steps in the procedure through which air traffic flight pattern changes may be approved.

COMMENT: Any change in air traffic flight pattern should be considered an alteration to an existing aeronautical facility and should require public notice and opportunity for comment.

RESPONSE: A change in an air traffic flight pattern is not an alteration. However, the input of the appropriate governing body of the affected municipalities will be considered when reviewing proposed changes to air traffic flight patterns.

COMMENT: The jurisdiction of noise, traffic patterns and all air space is under the governance of the FAA and therefore preempts those areas of your proposed regulations.

COMMENT: It is recommended that all sections in which federal jurisdiction takes precedent over state authority, including minimum pattern altitude requirement be remanded to reflect a commitment to better communication. Aeronautical facilities should be encouraged to notify the director of the Office of Aviation upon submission of the proposed change to the FAA, and again notify the office when a determination is made by that authorizing agency.

RESPONSE: While air traffic procedures are under the aegis of the FAA, the selection of a traffic pattern altitude within FAA altitude parameters is at the discretion of the airport owner. These regulations provide oversight of the altitude and pattern selected by the owner to ensure both are in the best interests of aviation and of the citizens of the state.

COMMENT: Exception is taken to the fact that the Commissioner has the ultimate authority as to flight patterns over residential areas.

RESPONSE: The Department fully recognizes Federal authority in this area. However, the FAA allows the airport owner to set specific air traffic pattern altitudes and pattern locations within their broad guidelines. The Office, as the State's technical expert on aviation matters, must ensure that the airport owner's selection of altitudes and patterns, within the FAA guidelines, consider the local interests in such determinations. The rule as written, however, implies that Office nonconcurrence could come after FAA approval. This is not the case and the wording has been revised to clarify that matter.

N.J.A.C. 16:54-5.1(e)

COMMENT: The establishment of noise abatement procedures is permissive and should be mandated. New Jersey should be taking the lead in creating noise abatement procedures, including such potential mechanisms as muffler requirements, curfews and most assuredly coordinating with local land use planners, rather than blanketly limiting their authority.

COMMENT: Local government should have the final word in such matters as noise abatement and flight patterns.

RESPONSE: Pursuant to FAR 157, establishment of noise abatement procedures is the responsibility of the licensee. The other areas discussed by the commenter regarding mufflers and curfews are preempted by the FAA. Regarding coordination, N.J.A.C. 16:54-5.1(d) and (e) have been expanded to provide that the Office will consider input from the appropriate governing bodies of the affected municipalities in these matters.

COMMENT: This section requires licensed aeronautical facilities to adopt appropriate noise abatement procedures in an effort to minimize any detrimental impact of aviation activities upon the general public. As the existing procedures for investigation of citizen complaints against airport operations and individual pilots are ineffective and cumbersome, aeronautical facilities should be required to maintain logs of departing and incoming aircraft sufficient to identify that aircraft and its operator in the event of a legitimate citizen complaint. Maintenance of such logs should be a requirement for the issuance or renewal of a license to operate an aeronautical facility.

RESPONSE: Mandating a requirement for logging of all operations at all aeronautical facilities is an overly burdensome task and does not assure that an offending aircraft would, in fact, be logged. Therefore, no change has been made.

COMMENT: While an airport proprietor may implement noise abatement procedures that are reasonable and nondiscriminatory, the State

may not require an airport proprietor to do so, because of preemption by the FAA.

RESPONSE: The commenter is correct in noting that the FAA preempts aircraft noise at its source. These rules, however, do not usurp that Federal power. On the other hand, the FAA delegates responsibility for airport noise abatement procedures to the individual airport owners. These rules which have been coordinated with the FAA, focus on airport noise abatement procedures and ensure that the best interests of aviation and the general public are protected.

N.J.A.C. 16:54-5.2(a)2

COMMENT: Federal regulations addresses this issue on airports certificated under FAR Part 139 and on which scheduled air carrier operations occur. Even within this scenario, FAA does not prohibit vehicle access to general aviation areas, and does not advocate any vehicle access deterrents at general aviation airports. The State should not be involved in any process of advocating vehicle access deterrents at general aviation airports.

RESPONSE: These rules do not prohibit vehicle access at general aviation airports. However, it is necessary for aeronautical facilities to have a method to control vehicle access to the aircraft operating area to ensure safety. These rules provide the licensee with a mechanism for that control.

N.J.A.C. 16:54-5.2(a)3

COMMENT: The requirement for snow and ice removal may not be practical at many public use, privately owned turf airstrips in the State. SASP tier four airports should be allowed to close when they cannot possibly be used. It is recognized that these are limited use facilities in winter weather.

RESPONSE: The requirement is for the licensee to formalize the facility's procedures for snow removal, even if these procedures are to close the facility until the snow melts.

N.J.A.C. 16:54-5.2(b)

COMMENT: This [subsection] calls for operating procedures to be outlined for ground operating procedures. The ground operating procedures should be contained in the general operating procedures, rather than having specific sections of its own.

RESPONSE: The rules do not specify that ground operating procedures must be included in a separate section. The ground operating procedures are to be a part of the General Operating Rules in accordance with N.J.A.C. 16:54-3.2(a), formerly, N.J.A.C. 16:54-3.2(f).

N.J.A.C. 16:54-5.2(c)

COMMENT: The procedures outlined skirt the very real issue of aircraft noise and airport neighbors by giving the authority to the Director. Not that we have any objections to empowering the Director to impose noise abatement procedures, but it is also our opinion that the rule becomes more acceptable if it adds a requirement for a public hearing with public and pilot input before such procedures are adopted.

RESPONSE: The provision cited gives the Director the authority to require an aeronautical facility to implement the provisions of N.J.A.C. 16:54-5.1(e), under which the Office considers input of the affected municipalities.

N.J.A.C. 16:54-5.2(f)

COMMENT: This [subsection] should be clarified to reflect that minimum altitude applied to all aircraft. Further, the "operational consideration" should be clearly identified.

COMMENT: The "operational considerations" should be changed to "except where necessary for take off or landing," to be consistent with existing regulations.

RESPONSE: The traffic pattern altitude referred to in this rule applies only to fixed wing aircraft. The rule has been clarified to reflect that provision. Operational considerations pertain to terrain or other physical constraints or to aircraft or airspace conditions. They cannot be specifically identified because they will vary from facility to facility. Take offs and landings are not operational considerations related to this rule.

COMMENT: A very important issue is "liability". Is the state willing to assume the liability of the traffic pattern if the Office of Aviation sets the altitude and any alteration? The FAA has deliberately avoided this area as it is not willing to assume the liability.

RESPONSE: The Office reviews and approves the altitude and pattern set by the owner to ensure safety and to consider input from the county. The 1,000 foot minimum is set for standardization statewide according to the FAA and N.J.S.A. 6:2. A traffic pattern, assigned altitude, or even an FAA clearance does not release a pilot from any responsibility for his or her actions.

COMMENT: Traffic pattern altitude should be specified as a standard minimum of 1,200 feet, absent a demonstration of unique and compelling safety considerations or the existence of non-inhabited areas. Minimum altitudes for all purposes for all types of aircraft should be 1,000 feet above surface level (ASL). The regulation should state that no traffic or take-off or landing pattern will be approved that does not comply with these requirements, unless there is no other available alternative to meet them or, again, upon a demonstration of overriding safety considerations.

COMMENT: Traffic patterns for smaller aircraft are normally 800 feet AGL. SASP tier 4 airports should have the option of electing an appropriate traffic pattern altitude.

RESPONSE: By setting a standard traffic pattern altitude of 1,000 feet for fixed wing aircraft at public use airports, a Statewide standard is maintained which enhances safety of flight.

COMMENT: Considerations should be spelled out in the regulations relating to required safe operations, e.g., prohibitions against practice stall-outs over inhabited areas, restrictions against formational and stunt flying over inhabited areas and any other significant safety criteria, perhaps by incorporating specifically relevant AOPA or other standards and by express provision.

RESPONSE: In-flight operations are under the jurisdiction of the FAA, which preempts the field.

N.J.A.C. 16:54-5.3

COMMENT: An exception should be written to the proposal to allow for "emergency use" of any private or restricted use strip by air ambulances, aerial fire fighting equipment and search and rescue aircraft without violating the restricted portions of the Act as it pertains to a particular strip.

RESPONSE: A separate regulatory provision regarding temporary "Official Use Helistops" declared by government officials or law enforcement agencies is being reviewed and may be promulgated at some point in the future.

N.J.A.C. 16:54-6.1

COMMENT: Temporary Helistop Operations—In the past I've always been able to call the office and say thank you, this is what we've done, and notify them. I would hope that in the future we can still continue this relationship.

RESPONSE: Prior approval is, and has always been, a prerequisite to any temporary helicopter operation. After-the-fact notices do not conform with the requirements of these rules.

N.J.A.C. 16:54-6.1(e)

COMMENT: Municipal bodies lack the necessary qualifications to make objective, informed judgements about aviation matters and all such decisions should be left solely to the Commissioner and/or the FAA.

RESPONSE: The Legislature has empowered the Commissioner to make decisions regarding aviation matters. However, the Office recognizes the need for input from the appropriate governing body and also recognizes that the appropriate governing body has the qualifications necessary to determine if the proposed facility conforms to the local land use ordinances. However, since the local input set forth in N.J.A.C. 16:54-6.1(e) appropriately applies to temporary licenses, pending issuance of a permanent license, the concept set forth is being relocated and clarified under N.J.A.C. 16:54-6.2(e).

N.J.A.C. 16:54-6.2(a)3

COMMENT: Provisions for one-time or one-day temporary helistops should be incorporated in current laws, permitting the Office of Aviation to grant such via telephone call or fax from a reputable and responsible operator known to the Office.

RESPONSE: A provision for submitting an application less than 10 days prior to the requested start date has been added, provided that the applicant submits justification. N.J.A.C. 16:54-6.2(a)3 has added "unless a shorter time period can be justified by the applicant". However, in response to the comment regarding telephone approval for responsible operators, the State cannot, in this case, promulgate a rule that gives priority to any applicant or class of applicant. Every applicant is entitled to equal treatment.

N.J.A.C. 16:54-7

COMMENT: Throughout this subchapter has there been any criteria established upon which the Director will grant waivers and exemptions? The language is vague and leaves too much to the whim of the Office of Aviation and its staff.

RESPONSE: Criteria for waivers and exemptions are set forth in the rules, at N.J.A.C. 16:54-7.1. The rules also require supporting justification to be submitted with the waiver request. This provides sufficient foundation upon which the Director can base a decision.

COMMENT: Throughout the publication it states that waivers may be issued and that "all decisions are within a purview of the Commissioner." In other words, the regulations state what you must do and then they are always subject to change.

RESPONSE: While the rules cover the majority of cases, there may be exceptional situations which must be specifically addressed by the Commissioner either through a waiver or through the exemption process.

N.J.A.C. 16:54-7.1

COMMENT: There is concern that an exemption from some of the more restrictive regulations requires a waiver from the director who may not treat it fairly because of political involvement or competency.

RESPONSE: The provisions for waivers and exemptions are clearly set forth and will apply uniformly to all applicants and licensees. The rules provide that applicants or licensees who are denied a waiver or exemption may exercise their rights to appeal.

N.J.A.C. 16:54-7.2

COMMENT: Our Special Landing Strip Certificate and Official Use Helistops are exceptional circumstances that will warrant several waivers and exemptions under N.J.A.C. 16:54-7.2 and 7.3.

RESPONSE: Requests for waiver or exemptions may be made at any time in accordance with the provisions cited.

N.J.A.C. 16:54-8.3

COMMENT: The language contained herein appears to be rather stringent and should be modified to encourage voluntary compliance.

RESPONSE: The language in the rules is being modified in order to allow flexibility when the magnitude of an inadvertent misrepresentation or false statement is so minor as to not adversely affect the operational safety of the facility and when the misrepresentation or false statement was not intentionally or knowingly made. A provision has been added to suspend, or extend the suspension of, rather than to revoke, a license; and, under circumstances where public health, safety or welfare requires that the license not be suspended, to forego suspension, based on the Commissioner's determination.

N.J.A.C. 16:54-8.3(a)

COMMENT: The regulation should be amended to read "any person who knowingly makes a misrepresentation. . . ."

RESPONSE: "Knowingly" should not be included. There could be an impact on safety whether known to the applicant or not. Therefore, N.J.A.C. 16:54-8.3 is reworded to state: "Corrections shall be made within 30 days, or the Commissioner may then suspend, further suspend, or revoke. . . ."

N.J.A.C. 16:54-8.5

COMMENT: In the area regarding penalty, $1,000 per violation is overkill. It should be something considerably less or only in the gravest of violations should that much of a violation be levied.

COMMENT: The promulgation of rules are all well and good, however, without adequate monitoring and enforcement the rights of citizens will not be protected.

RESPONSE: The provisions of the chapter adequately address penalties to be assessed, in accordance with N.J.S.A. 6:1-59 and 59.1. Specific penalty is determined by the court of appropriate jurisdiction. The Office is charged with the responsibility to enforce those provisions, and intends to do so.

N.J.A.C. 16:54-8.5(b)

COMMENT: In view of the Department's limited resources and insufficient staff, substantial penalty provisions are necessary to sufficiently protect both the flying and non-flying public. The specific penalties, particularly with respect to safety violations and willful omissions, are insufficient to deter violators, by a wide margin.

COMMENT: A $1,000.00 penalty per violation is entirely too great a cost burden for a small business, fixed based operation or airport owner. A more realistic $100.00 penalty per violation is appropriate and sufficiently discouraging.

RESPONSE: The penalty range is set by statute (N.J.S.A. 6:1-59 and 59.1). It must be recognized that safety requirements are important and must be met. These stringent penalties act as a strong deterrent to allowing or committing a violation.

N.J.A.C. 16:54-9

COMMENT: The language contained herein appears to be rather stringent and should be modified to encourage voluntary compliance.

COMMENT: The power of suspension granted to a designated representative of the Commissioner is entirely too broad. The power to suspend a license should be strictly reserved to the Director or the Commissioner on the event of their inspection of a suspected violation. Not all "designated representatives" may be competent or qualified to make a judgment call that will affect an operator's livelihood.

RESPONSE: Suspensions of an aeronautical facility license will only occur in safety related situations. The language is being clarified and the provisions for suspension are being limited to 90 days. In addition, the adoption makes clear that the personnel currently identified in N.J.A.C. 16:60-1.3 law enforcement officers are the Department's designated representatives and will continue to be authorized to take such actions. The addition of a 90-day limit clarifies the rule for the regulated public, limiting the duration of the suspension in response to the commenter's request.

N.J.A.C. 16:54-10

COMMENT: The rules tend to empower the Commissioner to override the concerns and objections of local homeowners who oppose the project and subvert the venerable principle of home rule.

RESPONSE: While statutorily empowered with jurisdiction over aeronautics within the State, the Commissioner must, in matters regarding the licensing of aeronautical facilities, consider the local interests, compatibility of land use, and the local zoning ordinances, in making a decision. The Commissioner will continue to weigh these factors when exercising these regulatory powers.

COMMENT: Interpretation of the law in emergency situations should be made swiftly and decisively by the Commissioner, thereby reducing the chance that a relatively minor dispute will erupt into an expensive and drawn out court battle.

RESPONSE: The Commissioner acts as expeditiously as is prudent in a given situation. Before acting however, the Commissioner must consider all the necessary information. Although obtaining the relevant information may take some additional time, it will ensure that there is an accurate factual basis upon which to make a decision.

COMMENT: It is recommended that a clause in Subchapter 10, Powers, be added to read: "The Commissioner shall intercede promptly when a local governing body incorporates regulations which are preempted by the state and federal authorities."

RESPONSE: The powers of the Commissioner, as set forth in this section, are sufficient to permit him or her to properly discharge his or her duties.

General Comments

COMMENT: Concur with the proposed rules to the fullest extent. Without proper rules and regulations, confusion, congestion and safety can not and will not be controlled. The Office of Aviation should be sufficiently staffed, so as to conduct more frequent visits and inspections to airports, to become more familiar with their day to day operations.

RESPONSE: Noted.

COMMENT: The regulations are well written and need to be implemented as soon as possible. Further postponement, for whatever reason should not be granted. The issues have been debated long enough.

RESPONSE: Noted.

COMMENT: Both the Director and the Office are to be complimented for their effort and their diligence in bringing about this much needed clarification as to the standards under which aeronautical and aerospace facilities are to be operated in New Jersey. Hopefully, this will be the beginning of an era in aviation where it will be recognized as a vital part of the state and local community. To that end, each of us associated with aviation needs to continue our effort to establish ourselves and the industry as a good neighbor and a welcome part of our respective communities. Again, kudos to the Director and the Office.

RESPONSE: Noted.

COMMENT: We must question what efforts, if any, the DOT staff made to work with local governments and citizen representatives in the development of the proposed rules.

COMMENT: The earnestness of the DOT to be responsive to concerns of local governments is less than apparent.

COMMENT: We urge that the Department enter into meaningful consultation with all affected parties (communities, non-aviation public).

RESPONSE: The Department worked earnestly with all municipalities as well as with other groups and agencies to ensure adequate input to this chapter. Municipalities requested several meetings with the DOT regarding the proposed rules. Every request resulted in a meeting. A day-long seminar regarding these regulations was held in response to a request by the League of Municipalities and the Council of Mayors. In addition, the comment period was twice extended in response to requests from municipalities and the general public.

Summary of Agency-Initiated Changes:

The Department has amended N.J.A.C. 16:54-2.1 to delete the phrase "deactivation or abandonment," in order to avoid duplication of the provisions of N.J.A.C. 16:54-2.10(a)3. The Department has also deleted the text at N.J.A.C. 16:54-3.1(h), since this text duplicates the requirements contained in N.J.A.C. 16:54-8.3.

N.J.A.C. 16:54-4.2(a)1i has been amended to transfer the standards included in the definition of effective length at N.J.A.C. 16:54-1.3 to a more appropriate section of the chapter.

The Department has amended N.J.A.C. 16:54-4.2, 4.3 and 4.4 to correct a typographical error in the citation of FAA documents, from 150/5340 to 150/5390. Additionally, changes have been made to the rules to further specify the proposed requirements on restricted use facilities, in accordance with the FAA guidelines. These changes are consistent with the Department's requirement for other types of facilities, and with the industry standards provided by the United States Parachute Association. The marker requirements are not unduly burdensome, the Department believes, since they can be complied with by using, for example, an orange frisbee, a generally inexpensive item.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

CHAPTER 54
LICENSING OF AERONAUTICAL AND AEROSPACE FACILITIES

SUBCHAPTER 1. GENERAL PROVISIONS

16:54-1.1 Scope

(a) This chapter lists and defines those types of aeronautical and aerospace facilities which must be licensed by the State of New Jersey and includes the ancillary operations thereon as hereinafter defined; outlines the procedures for obtaining license(s); specifies the licensing requirements which applicants must meet; specifies the minimum acceptable design standards for each type of facility; specifies certain operational standards for each type of facility; specifies the liability and penalty for failure to observe the requirements; and describes the procedure for requesting exemption from these rules.

(b) The rules specified in this chapter, if not in conformity with the laws, rules, and regulations concerning aeronautics set forth by the Federal Aviation Administration or the National Aeronautics and Space Administration, are subject to preemption. If not specifically preempted by Federal standards, the ultimate authority over the regulating and licensing of aeronautical activities and facilities in New Jersey resides with the Commissioner, as provided for in N.J.S.A. 6:1-29 et seq.

16:54-1.2 Applicability

(a) The provisions of this chapter apply to the following types of aeronautical facilities:

1. Fixed wing aeronautical facility:
i. Airport—Public Use (land or water);
ii. Airport—Restricted Use (land or water); and
iii. Airport—Special Use (land or water);
2. Vertical flight aeronautical facility:
i. Heliport—Public Use;
ii. Helistop—Restricted Use;
iii. Helistop—Special Use;
iv. Vertiport—Public Use;
v. Vertiport—Restricted Use; and
vi. Vertiport—Special Use;
3. Lighter than air aeronautical facility:
i. Balloonport—Public Use;
ii. Balloonport—Restricted Use;
iii. Balloonport—Special Use;
iv. Airship Base—Public Use;
v. Airship Base—Restricted Use; and
vi. Airship Base—Special Use;
4. Parachute drop zone aeronautical facility:
i. Parachute Drop Zone—Public Use;
ii. Parachute Drop Zone—Restricted Use; and
iii. Parachute Drop Zone—Special Use;
5. Aerospace facilities (Reserved); and
6. Temporary aeronautical facilities:
i. Airship Base;
ii. Balloonport;
iii. Helistop;
iv. Landing Strip;
v. Parachute Drop Zone;
vi. Vertiport; and
vii. Other.

(b) Effective 180 days after the effective date of this chapter, all license applications and renewal applications shall comply fully with the requirements of N.J.A.C. 16:54-3.2.

(c) Existing aeronautical facilities which do not meet specific physical dimensional criteria or requirements of these revised regulations shall have two years to come into compliance. During that period, the licensee shall either make provisions to comply or petition for an exemption from the criteria as provided for in N.J.A.C. 16:54-7.

(d) Existing aeronautical facilities which do not meet the requirements of these regulations, other than those described in N.J.A.C. 16:54-1.2(b) or (c) shall have one year to come into compliance. During that period, the licensee shall make provisions to comply with the requirement or to petition for an exemption as provided for in N.J.A.C. 16:54-7.

16:54-1.3 Definitions

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

"Accident" means an occurrence associated with the operation of an aircraft which takes place between the time any person boards the aircraft with the intention of flight and when all such persons have disembarked, and in which any person suffers death or serious injury, or in which the aircraft receives substantial damage.

"Aeronautical activity" means any of the following aviation related commercial activities generally provided to the public or any segment thereof, at an aeronautical facility either by the licensee or his tenants or invitees, with or without compensation:

*[1. Aircraft operations, sales, rental, use, storage, and flight or ground training and examination;

2. Aircraft fueling, servicing, maintenance, repair, parts, construction, and training; and

3. Parachute operations, sales, use, rigging, maintenance, repair, construction, and training.]*

1. Aircraft: sales, charter, rental, lease, storage, operation, hangaring, tiedown, and parking; and parachuting operations;

2. Instruction: aircraft flight and ground instruction of all types, license examinations and proficiency checks, crew member training, parachute jumping training,

3. Maintenance: all types of maintenance, repair, inspection, testing, modification, overhaul, corrosion control or painting of aircraft, engines, systems, avionics, parachutes, or ancillary air or ground support equipment; and

4. Servicing: aircraft fueling using fixed, hydrant, mobile, or portable equipment; aircraft engine or systems servicing including

hydraulics, pneumatics, oxygen, lavatory, aircraft catering, electronics, aircraft cleaning.*

"Aeronautical facility" means any airport, seaplane base, heliport, helistop, drop zone, blimp mooring mast, balloonport, or vertiport.

1. The facility includes all property, paving, appliances, structures, seaplane docks, runways, taxiways, seaways, sealanes, aprons, hangars, or safety equipment associated with the aeronautical activities conducted on the premises and property.

"Aerospace facility" is any facility used for the launch or recovery of spacecraft.

"AGL" means above ground level.

"Aircraft" means any contrivance now known or hereafter invented, used or designed for air navigation or flight in the air. It includes, but is not limited to: airplanes, airships, blimps, dirigibles, gyroplanes, gliders, helicopters, hot air or gas balloons, seaplanes, tiltrotors, and ultra lights.

"Air navigation" means the operating, steering, directing, or managing of aircraft in or through the air, and on the ground or water.

"Airplane" means an engine-driven, fixed-wing aircraft that is heavier than air *[that is]* ***and*** supported in flight by the dynamic reaction of air against its wings.

"Airport" means a designated area of land, water, or both, which is licensed for the landing and takeoff of airplanes and other aircraft, and which may provide facilities for shelter, security, and service of aircraft.

"Airport layout plan (ALP)" means *[the plan.]* ***a graphic presentation to scale of existing and proposed facilities at an aeronautical facility. It includes their location on the site and the pertinent clearance and dimensional information required to show conformity with applicable standards.***

"Airport reference point (ARP)" means the centroid of the runways plotted using formulas found in FAA A/C 150-5300-13. The ARP is identified in latitude and longitude to the hundredth of a second.

"Airship" means an aircraft, lighter than air, engine driven that can be steered.

"Airship base" means any area of land or water of defined dimensions licensed for the takeoff and landing of airships.

"Alteration" means any construction, demolition, or modification to the surface, design, or operational areas of an aeronautical facility which affects, increases, or diminishes its operational capabilities.

"Approach/departure path" *[(pertains to operation of vertical flight aircraft)]* means a prescribed *[flight track]* ***area*** extending outward and upward *[from the edge of]* ***at a prescribed ratio from*** a landing *[and]* ***or*** takeoff area, along *[which normal flight is]* ***the intended route of flight*** conducted *[to and from]* ***into or out of*** an approved aeronautical facility.

"Appropriate governing body" means the entity which has ultimate governing responsibility for the political subdivision in which the aeronautical facility or proposed aeronautical facility is located. For aeronautical facilities at which the provisions of N.J.S.A. 6:1-80 et seq., Airport Safety Zoning Act apply, this definition shall include all those political subdivisions in which the airport safety zone is located.

"Balloon" means a lighter than air aircraft whose lift is derived from the buoyancy of hot air or certain gases and which is not engine driven.

"Balloonport" means any areas of land or water of defined dimensions licensed for the takeoff of manned, free-flight balloons.

"Building restriction line" means a line that is a specified distance from the centerline of a runway.

"Certified drawing" means a drawing certified as accurate by a licensed land surveyor, licensed professional planner or licensed professional engineer, and bearing the raised seal of the person certifying the drawing.

"Commissioner" means the Commissioner of the New Jersey Department of Transportation.

["Crew member"] ***"Crewmember"*** means an individual *[used to assist]* ***who assists*** in the preflight inflation, launch, chase, landing (arrival) and recovery of a balloon; or any person authorized and assigned to perform duties in any aircraft during flight.

"Department" or "DOT" means the New Jersey Department of Transportation.

"Director" means the Director of the Office of Aviation in the New Jersey Department of Transportation.

"Effective runway length" means that distance on a runway, beginning at a point on the runway surface where the obstruction free, applicable approach slope intersects the runway, and measured along the runway centerline to the end of the runway in the landing direction.

"Exemption" means relief from a specific provision of this rule permanently or for a specified extended period of time.

"FAA" means the Federal Aviation Administration.

"Free-flight" *[(pertains to the operation of balloons)]* means the act of flying a manned balloon which is not tethered to the ground.

"Helicopter" means a rotary wing aircraft that depends principally upon the lift generated by engine-driven rotors rotating on a substantially vertical axis for its primary means of propulsion.

"Heliport" means a dedicated area of defined dimensions, either at ground level or elevated on a structure, designated for the landing or take off of helicopters and used solely for that purpose.

"Helistop" means an area of defined dimensions, either at ground level or elevated on a structure designated for the landing or take off of helicopters, but not limited in use to that sole purpose. Helistops generally provide minimal or no support facilities and may be located in multiple use areas such as parking lots, dock areas, parks, athletic fields or other suitable open areas.

"Incident" means an occurrence other than an accident, associated with the operation of an aircraft, which affects or could affect the safety of operation of an aircraft, or which affects or could affect the operational capability of an aeronautical facility, or in which any person suffered an injury which was not a serious injury and which did not result in death.

"Landing and takeoff area" *[(pertains to the operation of helicopters)]* means a specific area of defined dimensions to which the helicopter approaches for landing or from which it departs, and includes the touchdown area.

"Licensee" means any person(s) whose name appears on the license of, and who is responsible for, or who controls operations at, an aeronautical facility.

"M" means meters, as a unit of measurement.

"MSL" means mean sea level.

"Moored or tethered flight" means the act of operating a balloon secured to the ground by sufficient and suitable means to permit vertical movements where no intention of launch into free-flight exists.

"NASA" means the National Aeronautics and Space Administration.

"Notice to Airmen (NOTAM)" means a notice containing information concerning the establishment, condition, or change in any component, facility, service, or procedure of, or hazard in the National Airspace System, the timely knowledge of which is essential to personnel concerned with flight operations.

"NTSB" means the National Transportation Safety Board.

"Obstruction to air navigation" means an object of greater height than any of the heights or surfaces presented in Subpart C of FAA Regulations Part 77. *[(]*Obstructions to air navigation are presumed to be hazards to air navigation unless an FAA study has determined otherwise.*[)]*

"Office" means the Office of Aviation in the New Jersey Department of Transportation.

"Parachute drop zone" means an area of defined dimensions, on the earth's surface, designated for the landing of parachutists.

"Parachuting exhibition" means the operation by specially qualified individual(s) engaged in parachuting to a specifically authorized drop zone, for exhibition purposes.

"Public use aeronautical facility" means any area of land, water, or both which is licensed for the landing or take off of aircraft and

open to the public for aeronautical operations. Public use aeronautical facilities may be utilized, advertised, and represented as such.

"Reference point" *[(heliports and helistops only)]* means a point on the earth's surface, identified in terms of latitude and longitude to the nearest second, from which all linear measurements originate when applying the criteria of this *[sub]*chapter to helicopter facilities. The facility reference point will always be the exact center of the helicopter touchdown area.

"Restricted use aeronautical facility" means any area of land, water or both, which is licensed for the landing or take off of aircraft under the conditions or restrictions imposed by the Office of Aviation, the licensee, or both.

"Runway" means a defined rectangular area of airport land prepared for the landing or take off of aircraft along its length.

"Runway safety area" means an area in which a runway is symmetrically located and is graded to be smooth and level. These areas are to be maintained in such a condition that aircraft operating thereon may do so, safely with no damage.

"Safety area" means a safety zone that provides an additional obstruction-free surface on all sides of a prescribed helicopter landing and *[take off]* ***takeoff*** area.

"Safety zone area" means any area of land or water or both, upon which an aeronautical hazard might be created or established.

"Sealane" means a designated portion of water intended to be used by aircraft designed to operate on water.

"Seaplane base" means any landing area of water (with or without land support facilities) that is licensed for the landing or take off of aircraft that are able to utilize a water surface.

"Shelter" means an enclosed structure to provide for the comfort of persons against rain, wind, sun and adverse water.

"Spaceport" is any aerospace facility.

"Special use aeronautical facility" means any area of land, water or both which is licensed for the landing and *[take off]* ***takeoff*** of ***specifically*** designated aircraft ***piloted*** by *[specified]* ***specifically identified*** individuals, as authorized by the Office, ***in writing on the license, or on an attachment to that license.***

"Taxiing" means a powered movement of an aircraft on the ground or water from one area to another. This definition includes hover-taxi as well as ground taxi for helicopters depending on the type of landing gear and the surface area being used.

"Taxiway" means a defined pathway established for movement of an aircraft on an aeronautical facility.

"Touchdown area" means a defined part of an aeronautical facility to which a helicopter shall approach and actually alight (or come to a zero forward ground speed hover, from the approach, prior to touchdown or taxiing to another area) and from which helicopter departures shall originate.

"Touchdown pad" means a designated area of an aeronautical facility on which a helicopter will actually alight.

"Vertical flight aircraft" means any ***powered*** aircraft which is capable of vertical or near vertical *[take off]* ***takeoff*** and landing operations including but not limited to rotor wing aircraft, tiltrotor aircraft, tilt wing aircraft, and fan in wing aircraft.

"Vertiport" means any area of land or water or elevated area of defined dimensions licensed for the take off and landing of vertical flight aircraft.

"VFR" means visual flying rules.

"Waiver" means relief from application requirements of this rule or temporary relief from other provisions of this rule for a specified limited time period.

16:54-1.4 Definitions incorporated by reference

Other definitions as described in Title 14 Code of Federal Regulations, Chapter 1 through 199, the FAA Airman's Information Manual and FAA Advisory Circulars are incorporated herein by reference, and all amendments thereto, except where the definitions are inconsistent with this chapter, in which case, this chapter shall control.

SUBCHAPTER 2. APPLICATION FOR LICENSE

16:54-2.1 Application forms for permanent facilities

(a) All persons proposing the opening of a new aeronautical facility, the alteration to, or deactivation or abandonment of, an existing aeronautical facility listed in N.J.A.C. 16:54-1.2 shall ***submit an application to the Office and shall***:

1. Submit an "Application for Aeronautical Facility License," Form DA-1, and "Aeronautical Facility Agreement," Form DA-2, or "Application for Aeronautical Facility Alteration, Deactivation, or Abandonment," Form DA-3, including all applicable attachments and FAA Form 7480-1 "Notice of Landing Area Proposal" if required. Such application shall include, at a minimum:

i. For Form DA-1 applications, all of the items listed in this section as applicable to the type of facility desired;

ii. For Form DA-3 applications, resubmission of required attachments *[which are presently on file in the Office, with current date (may be waived by the Director)]* ***may be waived if the attachments are currently on file in the Office, and show current data***;

iii. A description of the expected use and activity level of the new or altered facility;

iv. A certificate or statement from the applicant that he has *[advised]* ***notified*** the appropriate governing body ***and county authorities in the county where the facility, or proposed facility is located*** in writing, by personal delivery or certified mail, return receipt requested, of *[his proposed]* ***the*** action, *[as submitted]* ***proposed*** in the application;

v. Additional materials as may be requested by the Director, to substantiate the application; and

vi. The appropriate application fee in accordance with the provisions of N.J.A.C. 16:63.

2. Unless otherwise specified herein, submit a scaled certified plan drawing or an annotated scaled aerial photograph, and a scaled certified profile drawing, showing the specific information required for the specific type of facility.

i. For airports or landing strips, a scale of one inch equals 400 feet shall be used showing:

(1) True north;

(2) Latitude and longitude to the nearest ***ten thousandth of a minute or hundredth of a*** second;

(3) Field elevation (MSL);

(4) Actual length and width, of runway(s);

(5) Magnetic alignment of runway(s) to nearest second;

(6) Location(s) use, and height(s), of structures on or proposed for the facility.

(7) Location(s), use, and height(s) (MSL), of obstruction(s) in the Safety Zone Area if applicable;

(8) Location(s), use, and height(s) (MSL), of obstruction(s) ***at facilities***, where Safety Zoning does not apply, contiguous to the facility within at least 3,000 feet from the end of each runway and at least 500 feet from each side of the centerline of the runway(s);

(9) Proposed air traffic patterns superimposed on the drawing with pattern altitudes indicated;

(10) Include a listing of all aeronautical facilities located within five miles of the site; and

(11) Facility property lines and municipal boundaries.

ii. For heliports or helistops, a scale of one inch equals 50 feet shall be used, showing:

(1) True north;

(2) Latitude and longitude to the nearest ***ten thousandth of a minute or hundredth of a*** second;

(3) Field elevations (MSL);

(4) Actual dimensions of the touchdown area;

(5) Location(s) and height(s) (MSL) of any obstructions within a radius of 1,000 feet of the reference point;

(6) Location(s) of approach/departure path(s); and

(7) Facility property lines and municipal boundaries.

iii. Also for heliports and helistops, a scale of one inch equals 400 feet shall be used showing:

(1) Location(s) and height(s) (MSL) of any obstructions within a radius of 3,000 feet of the reference point;

(2) Location(s) of approach/departure path(s); and
(3) Facility property lines and municipal boundaries.
iv. For vertiports, a scale of one inch equals 100 feet shall be used, showing:
(1) True north;
(2) Latitude and longitude to the nearest ***ten thousandth of a minute or hundredth of a*** second;
(3) Field evaluation (MSL);
(4) Actual dimensions of the touchdown area;
(5) Magnetic alignment of runway(s) to nearest second; and
(6) Location(s), use, and height(s), of structures on or proposed for the facility.
v. Also for vertiports, a scale of one inch equals 400 feet shall also be used showing:
(1) Location(s), use, and height(s) (MSL), of obstruction(s) in the Safety Zone Area if applicable;
(2) Location(s), use, and height(s) (MSL), of obstruction(s) ***at facilities***, where Safety Zoning does not apply, contiguous to the facility within at least 3,000 feet from the end of each runway and at least 500 feet from each side of the centerline of the runway(s); and
(3) Proposed air traffic patterns superimposed on the drawing with pattern altitudes indicated.
vi. For balloonports, a scale of one inch equals 100 feet shall be used, showing:
(1) True north;
(2) Latitude and longitude to the nearest ***ten thousandth of a minute or hundredth of a*** second;
(3) Field elevation (MSL);
(4) Actual dimensions of the departure area;
(5) Location(s) and height(s) (MSL) of any obstructions within a radius of 1,000 feet of the center of the proposed facility; and
(6) Facility property lines and municipal boundaries.
vii. For airship bases, a scale of one inch equals 100 feet shall be used, showing:
(1) True north;
(2) Latitude and longitude to the nearest ***ten thousandth of a minute or hundredth of a*** second;
(3) Field evaluation (MSL);
(4) Actual dimensions of the operating area;
(5) Magnetic alignment of runway(s) to nearest second;
(6) Mast location and airship drift clearance; and
(7) Location(s), use, and height(s), of structures on or proposed for the facility.
viii. Also for airship bases, a scale of one inch equals 400 feet shall also be used showing:
(1) Location(s), use, and height(s) (MSL), of obstruction(s) in the Safety Zone Area if applicable;
(2) Location(s), use, and height(s) (MSL), of obstruction(s) ***at facilities***, where Safety Zoning does not apply, contiguous to the facility within at least 3,000 feet from the end of each runway and at least 500 feet from each side of the centerline of the runway(s);
(3) Proposed air traffic patterns superimposed on the drawing with pattern altitudes indicated; and
(4) Mast location and airship drift clearance.
ix. For parachute drop zones, a scale of one inch *[equal]* ***equals*** 400 feet shall be used, showing:
(1) True north;
(2) Latitude and longitude to the nearest ***ten thousandth of a minute or hundredth of a*** second;
(3) Actual dimensions of the drop zone;
(4) Locations, runway alignments, ***and*** traffic patterns of any other aeronautical facilities within 3,000 feet of the center of the drop zone;
(5) All roads, streets, powerlines, telephone lines, and bodies of water (where any depth at any time exceeds four feet), within 3,000 feet of the center of the drop zone;
(6) All buildings with heights above the drop zone elevation within 1,000 feet of the center of the drop zone; and
(7) All inhabited buildings within 1,000 feet of the center of the drop zone.
x. Parachute drop *[zones]* ***zone applications*** shall also include a listing of all aeronautical facilities located within five miles of the site.
xi. For banner towing facilities, include a sketch of the designated drop and *["]*pick-up*["]* area which shows the air traffic pattern for pick-up and drop of the banner.
xii. For minor alterations at restricted or special use facilities, the engineering certification is not required unless site requirements are such that the Director deems it necessary.
xiii. For abandonment or deactivation of any facility, certified drawings are not required.
3. Upon request by the Director, submit a *[narrative]* legal description, certified by a land surveyor or professional engineer licensed by the State Board of Professional Engineers and Land Surveyors as truly describing the site for which a license is requested or held.
4. For an elevated heliport or helistop, submit a certified drawing showing that the load bearing capability structural limits of any structure proposed is sufficient for the type of operations anticipated.
5. If the aeronautical facility premises are not owned by the applicant, the applicant shall:
i. Identify on the license application the owner(s) and any other parties who hold an interest in the property by lease or otherwise, and specify their interest; and
ii. Submit copies of all documents of title or interest to the Office upon request. Prior to licensing, the applicant shall submit written approval for the facility from the person(s) controlling the proposed facility premises.
*[6. Submit a statement or certificate, issued by the appropriate government body having jurisdiction, that the proposed facility or changes thereto, as submitted in the application, is in conformance or nonconformance with current land use ordinances; and that according to the plans, it can be constructed in accordance with State Uniform Construction Code and Uniform Fire Code. For the purposes of land use and zoning, any aeronautical activity is considered a permitted use at a public use aeronautical facility; and is considered a conditional use at restricted use and special use aeronautical facilities, subject to specific approval by the Office after coordination with, and input from, the appropriate local governing body.
i. If the relevant government authority does not provide such a statement as to land use ordinance compliance or noncompliance within 45 days of the date the application was submitted to them personally or through certified mail, return receipt requested, for response, the applicant shall submit such proof of submission and the application shall be considered to be in full compliance with local land use ordinance requirements for the purpose of this licensure application only;
ii. If the applicant is notified that the proposed facility is contrary to current land use ordinances, the applicant shall submit to the Office a copy of the application for local approval and the final decision which has been made, as well as copies of the certificate or statement of nonconformance, and all relevant provisions of the pertinent ordinances;]*
***6. In order to show conformance with existing zoning and land use ordinances, applicants shall:**
i. Submit a copy of the final determination, from the appropriate planning authority having jurisdiction, regarding the proposed changes or new facility, as submitted in the licensing application;
ii. Submit a copy of the certification, received from the appropriate planning authority having jurisdiction, which states that the application, as submitted, is deemed complete; in such cases, no final licensing decision will be made until the Department reviews and considers the final determination made by the appropriate planning authority having jurisdiction; or
iii. If the applicant is notified by the appropriate planning authority having jurisdiction that their final determination is to deny the application, the applicant shall submit to the Office a copy of the final determination plus relevant portions of the applicable ordinances;*

7. In addition to the *[approvals]* ***materials*** required in (a)***1 to*** 6 above, the applicant shall submit copies of permits, ***or*** applications ***for permits***, *[or if not yet approved,]* notices of intent, ***or other documents*** which are required by any other Federal, State, or local agency *[exercising control of designated land or water area]* ***with jurisdiction***. If only permit applications are submitted, final permits or letters of denial shall be submitted when received.

8. For *[deactivation or abandonment, or]* any change that will require relocation, transfer, or eviction of tenants, submit a plan explaining how facility tenants and/or users are to be notified, and what opportunities are available for relocation;

9. Applicants submitting requests under the requirements of N.J.S.A. 16:61 (Safety Fund Grants) are exempt from duplicate DA-1 and DA-2 requirements; and

10. Submit a completed copy of FAA Form 7480-1, "Notice of Proposed Construction or Alteration" (or subsequent form as amended or superseded) at the same time the form is submitted to the FAA.

(b) The applicant may request, in writing, waivers of application requirements to the Office. The Director may approve such waivers based on*[, but not limited to,]* the following:

1. Hardship to the applicant; or

2. Demonstrated substantial compliance with the provisions of this chapter; or

3. *[The]* ***When the*** scope and magnitude of the *[item]* ***requirement*** does not require full compliance.

16:54-2.2 Application forms for temporary facilities

(a) All persons proposing to operate temporary aeronautical facilities shall:

1. Submit an Application for Temporary Aeronautical Facility, Form DA-5, including all applicable attachments***, in accordance with the provisions of N.J.A.C. 16:54-2.1***; and

2. Comply with the provisions of N.J.A.C. 16:54-6.

16:54-2.3 Notice to the public

(a) The applicant shall publish a legal notice as shown in Appendix A, incorporated herein by reference, *[when required]* ***at a time specified*** by the Office *[of Aviation, the text of which will be provided by the Office of Aviation]*.

1. The legal notice shall be published in at least two newspapers serving the *[city, township, municipality, county or other political subdivisions]* ***jurisdiction of the appropriate governing body***.

2. One of the papers shall be the official publication designated by the *[political subdivision]* ***appropriate governing body*** for public notices and the second shall be the newspaper designated as secondary, or, if not so designated, shall be a newspaper circulated widely in that *[community]* ***political subdivision***.

(b) The notice shall contain the text prepared by the Office and shall provide ***a*** period for public comment and response of not less than *[15]* ***30*** days *[regarding all proposals to construct new aeronautical facilities]*. *[At the discretion of the Director, in accordance with N.J.A.C. 16:54-2.1(b), the publication requirements may be waived for a proposed alteration, deactivation or abandonment of an existing facility.]*

(c) The applicant shall submit, to the Office of Aviation, certified proof of publication in the two newspapers. Where the publication dates differ, the later publication date will be used by the Office in determining the public period for comment.

(d) Waivers to the notice requirement will not be given for any proposal to construct a new aeronautical facility. When waivers of the public notice requirement are granted in accordance with N.J.A.C. 16:54-2.1(b), the applicant shall still be required to notify the appropriate governing body, in writing, of the action being requested in the application.

16:54-2.4 Public hearing testimony

(a) The Commissioner may *[direct]* ***require*** that public hearings and/or informational meetings ***to*** be held regarding an application for license.

(b) The applicant shall be prepared to provide relevant data and information regarding the application at a public hearing or at any proceeding *[requested]* ***required*** by the Office. The applicant is responsible for preparing a formal transcript of the public hearing *[to be submitted]***, and submitting that transcript*** to the Office. Such hearing or proceeding shall be conducted at no cost to the *[State of New Jersey]* ***Department***.

16:54-2.5 Application processing

(a) All applications for aeronautical facility licenses shall be processed by the Office to ascertain that the minimum requirements of this chapter are met, *[as well as]* ***and to determine*** whether the issuance of such license *[considers the interest of]* ***would be consistent with*** public health***,*** *[and]* safety ***and welfare,*** and the development of aeronautics in the State. *[Factors such as]* ***In making its determination, the Office will consider aviation development,*** surrounding land uses, local *[zoning]* ***land use*** ordinances, topography, noise characteristics of the types of *[aeronautical equipment]* ***aircraft*** to be used, air traffic patterns proposed *[in the area]* ***to be used, air operational demand, aircraft movement operations, capacity of nearby aeronautical facilities, economic factors,*** and any other *[relevant information shall be part of the consideration required for such license processing]* ***factors deemed relevant by the Department***.

1. The Office reserves the right to approve the methods, standards, techniques, and sites to be used in the construction, change, modification, and/or alteration of new or existing aeronautical facilities *[sufficient]* to ensure compliance with reasonable engineering practices and *[to ensure that]* ***the*** safety of the public.

2. Any proposed changes to an approved application must be provided to the Director for review and approval before proceeding with the change. *[Substantive changes, proposed to an already submitted application, which]* ***Changes to a previously submitted application that would*** substantially change the impact ***of the facility*** on the contiguous land area or airspace, cannot be approved and will require the submission of a new application incorporating such changes.

16:54-2.6 Approvals

If the application is approved, the applicant shall receive a license, Form DA-L-1, Aeronautical Facility License, for the facility. If the application is disapproved, the applicant may petition the Commissioner for exemption in accordance with N.J.A.C. 16:54-7, Petition for Exemption.

16:54-2.7 Commencement of activities

No construction, alteration or closure shall occur until the applicant receives written approval from the Director.

16:54-2.8 Renewals

(a) All licenses expire on the last day of the 12th month following the date of issuance.

(b) The Office will renew an aeronautical facility license in accordance with the following procedures:

1. The Office will issue an aeronautical facility renewal, Form DA-4 which includes a facility inspection and certification attachment, to the licensee of record, not less than 30 days prior to the expiration of the current license.

2. The Office will issue to the appropriate governing body, a Notice of Intent to Renew the License for all public use aeronautical facilities.

*[2.]***3.*** Licensees shall conduct a facility inspection using the form provided *[certifying]* ***and shall certify*** that the facility is being maintained in compliance with the provisions of this chapter and any conditions stipulated in the license.

*[3.]***4.*** Licensees shall submit to the Office:

i. The renewal application, Form DA-4, with any changes annotated thereon,

ii. The appropriate renewal fee in accordance with the provisions of N.J.A.C. 16:63*[;]* ***and;***

iii. The completed facility inspection attachment Form DA-4 signed by the licensee.

*[4.]***5.*** The Office may conduct *[additional]* facility inspections to verify the information submitted in the renewal process.

[5. The Office will review the submitted renewal materials to determine their compliance.]

6. Upon review and determination that the licensee's renewal application, with attachments, is in compliance with this chapter the license will be renewed.

(c) Areas of non-compliance found during the review process will be reported to the licensee for corrective action. Licensees shall submit a plan for corrective action along with a schedule for accomplishing those actions. *[Renewal of a license may be withheld at the discretion of the Director pending compliance with these rules.]*

(d) *[Should the Director withhold a license renewal pending compliance, the licensee may petition the Commissioner for waiver or exemption in accordance with N.J.A.C. 16:54-7.]* ***Licensees may petition the Commissioner for a waiver or exemption from those requirements with which they are found in noncompliance.***

(e) The Director may extend for up to 90 days, any license issued by the Office, when requested by the licensee *[or the Office, and]* ***in order for the licensee to come into compliance or*** when the extension of such license is in the best interest of the public safety and the safety of those using the licensed aeronautical facility.

(f) If the licensee is not in compliance with this chapter and has not been granted a waiver or exemption, the license shall expire in accordance with the provisions of (a) above, or at the end of any extension period granted by the Director in accordance with (e) above.

16:54-2.9 License transfers

(a) Aeronautical facility licenses may be transferred under the following conditions:

1. The licensee shall submit a written request to the Office *[of Aviation]*, which includes a letter of intent to transfer ownership or control***, and must receive Office approval before proceeding with the transfer. The licensee shall submit a copy of that request, including a copy of the letter of intent, to the appropriate governing body.***

2. The new owner shall, within 30 days of the transfer of ownership or control, submit to the Office, a signed Form DA-2, Aeronautical Facility Agreement, and proof of legal transfer of ownership or control of the facility.

(b) Upon receipt of the documents required by (a) above, the Office may issue an amended license.

(c) Failure to comply with the provisions of this section will result in suspension of the facility license.

16:54-2.10 Abandonment, deactivation and surrender of license

(a) Licensees who wish to deactivate or abandon their facility shall:

1. Submit a completed copy of Form DA-3, Application for Aeronautical Facility Alteration Deactivation or Abandonment, to the Office not less than 30 days prior to the desired date of closure;

2. Submit a copy of FAA Form 7480-1, Notice of Proposed Construction or Alteration, (or subsequent form as amended or *[superceded]* ***superseded*** as submitted to the FAA requesting closure;

3. Submit a plan, satisfactory to the Director, explaining how facility tenants and or users are to be notified of the closure and what opportunities are available to them for relocation; and

4. Where applicable, the licensee shall submit a plan detailing how provisions of N.J.S.A. 6:1-94 (c) will be met.

(b) The Director shall determine, within 10 days of receipt of the application, whether the request to deactivate or abandon the facility is in the best interest of the State *[of New Jersey]*, the aviation community and the general public.

1. Licensees shall be notified *[within five days]* of the Director's decision concerning the application for abandonment or deactivation ***within 15 days of receipt of the application***.

2. The Director may delay the requested closure date pending compliance with the procedures in (a) above.

3. In the event that the Director determines that in the best interests of the State of New Jersey the aeronautical facility should remain open, he ***or she*** will recommend that the Commissioner exercise the authority granted under N.J.S.A. 6:1-95 to acquire the facility. ***If the Commissioner does not acquire the aeronautical facility, the licensee's request for abandonment or deactivation will be approved.***

(c) Licensees who have received approval to deactivate or abandon their facility shall surrender their license to the Office within 30 days after approval of the closure or within 30 days after actual closure, which ever comes later.

(d) Licensees whose license has been suspended or revoked shall immediately surrender their license to the Office or upon demand directly to any duly authorized representative of the Office.

SUBCHAPTER 3. GENERAL REQUIREMENTS

16:54-3.1 General requirements for all aeronautical facilities

(a) All aeronautical facilities and all operations at aeronautical facilities shall conform to the Federal Aviation Regulations of the United States, the laws of the State of New Jersey, the orders issued by the Commissioner, and the rules promulgated by the Department of Transportation.

(b) All licensed aeronautical facilities shall be maintained in a safe and hazard-free condition.

(c) Licensees shall provide safeguards acceptable to the Office to prevent inadvertent entry by unauthorized persons to the aeronautical operating area of the aeronautical facility. These safeguards shall be sufficient to prevent inadvertent entry at all times when flight operations are in progress or when aircraft are being operated or prepared for operations.

(d) Aircraft capable of meeting FAA certification specifications for landing or *[take off]* ***takeoff*** at ***an aeronautical facility of*** a specified size *[aeronautical facility shall]* ***may*** not be prohibited from using any public use aeronautical facility of that size or greater*[,]***.*** *[except when such]* ***Such*** use *[would violate]* ***shall be restricted or prohibited when it violates*** FAA or *[DOT]* ***Department*** rules or regulations*[, or]***.*** ***Such use may be restricted or prohibited when it*** would conflict with *[approved written standard procedures]* ***the aeronautical facility's Facility Management Standards or General Operating Rules*** prepared by the licensee in accordance with *[this chapter]* ***N.J.A.C. 16:54-3.2(a)**[.]* ***and as approved by the Office. Licensees who enter into agreements with others, restricting or prohibiting certain aeronautical activities, aircraft operations, or certain types of aircraft at their aeronautical facility shall include all such provisions in their Facility Management Standards and General Operating Rules. The Director may make such limitations a condition of the license.***

(e) Licensees shall provide the Office with the current name, home address and telephone numbers of the facility manager or responsible official who may be contacted at any time in case of emergency.

[(f) Any duly authorized representative of the Office, upon presentation of Department credentials shall be permitted to enter and inspect the premises at any time during scheduled hours of operation. Any such representative shall also be permitted to inspect all records and equipment during the inspection.]

(f) Facility inspections may be conducted at any aeronautical facility or proposed aeronautical facility in accordance with the following procedures:

1. Any duly authorized representative of the Office, upon presentation of Department credentials, will be permitted to enter and inspect the premises at any time during scheduled hours of operation.

2. Any such representative will be permitted to inspect all records and/or equipment related to the aeronautical facility during the inspection. The inspection may include:

i. An evaluation of compliance with industry standards;

ii. A review of the Facility Management Standards and General Operating Rules in use or proposed; and/or

iii. A safety inspection of the physical facility.

(g) The Certificate of License shall be displayed on the premises at all times, and shall be presented for inspection upon demand of any police officer of this State, or any representative of the Office.

[(h) If any information found in any license application or any additional information which may be submitted in connection therewith is found to be false, such false statements shall constitute good and sufficient cause for the Commissioner, at his or her discretion, to revoke any license issued based on that application.]

*[(i)]***(h)* Licensees shall not *[be convicted felons or]* have ***had more than one*** *[multiple suspensions]* ***suspension*** of ***a*** *[previous]* ***previously held*** aeronautical *[licenses]* ***license within the past five years***.

*[(j)]***(i)* Licensees *[shall be]* ***who are not*** residents of New Jersey *[or]* shall have an authorized agent registered with the State to act on ***their*** *[his]* behalf. ***Licensees that are corporations shall be registered to do business in New Jersey.***

*[(k)]***(j)* No buildings, structures, trees, or other permanent or semipermanent obstructions shall be built or located between the building restriction line and the runway.

16:54-3.2 General requirements for all public use aeronautical facilities

*[(a) Licensees shall establish and enforce written Aeronautical Activity Standards for the management and control of all aeronautical activities conducted at their facility. Such activities may include, but are not limited to:

1. Aircraft: sales, charter, rental, lease, storage, hangaring, tiedown, and aircraft parking;

2. Instruction: aircraft flight and ground instruction of all types, license examinations and proficiency checks, crew member training, parachute jumping training;

3. Maintenance: all types of maintenance, repair, inspection, testing, modification, overhaul, corrosion control or painting on aircraft, engines, systems, avionics, parachutes, or ancillary air or ground support equipment;

4. Servicing: aircraft fueling using fixed, hydrant, mobile or portable equipment; aircraft engine or systems servicing including hydraulics, pneumatics, oxygen, lavatory, catering, electronics, aircraft cleaning; and

5. Other usually recognized aeronautical activities, including any activity specifically approved by the Commissioner.

(b) Written standards required in (a) above shall be reviewed and approved by the Office, as follows. Licensees shall:

1. Notify the Office in writing that such aeronautical activities occur at the facility;

2. Submit copies of the procedures for review; and

3. Open the facility to inspections by any duly authorized representative of the Office during scheduled hours of operation. Office representatives shall also be permitted to inspect all records and equipment. The inspection may include:

i. An evaluation of general compliance with industry standards;

ii. A review of the implementation of the written operating procedures in use or proposed; and/or

iii. A safety inspection of the physical facility.

(c) Licensees shall post the approved Aeronautical Activity Standards in a conspicuous place at the aeronautical facility. Licensees shall provide copies of the approved standards for tenants and those others engaged in aeronautical activities at the facility. Licensees shall make copies available to other users of the facility.]*

(a) Licensees shall establish written aeronautical facility General Operating Rules to ensure the public safety, the safety of the general flying public, and the safety of those using the aeronautical facility. Licensees shall submit their proposed rules to the Director for review and approval. Upon approval, the licensee shall distribute the General Operating Rules to all tenants and make the rules available to other users and the general public at the cost of reproduction. In addition, the licensee shall post the rules in conspicuous places at the aeronautical facility.

(b) Aeronautical activities may be conducted at public use aeronautical facilities. For the purposes of land use and zoning, aeronautical activity(ies) are normally considered permitted uses at public use aeronautical facilities.

(c) Licensees shall establish and enforce written Facility Management Standards to ensure adequate oversight and control of aeronautical activities conducted at their facility. The Facility Management Standards shall be reviewed and approved by the Office, as follows:

1. Licensees shall:

i. Notify the Office in writing that such aeronautical activities occur at the facility;

ii. Submit copies of the Facility Management Standards for review; and

iii. Open the facility to inspections by any duly authorized representative of the Office during scheduled hours of operations. The inspection may include:

(1) An evaluation of general compliance with industry standards;

(2) A review of the implementation of the Facility Management Standards in use or proposed; and/or

(3) A safety inspection of the facility.

2. Licensees shall be notified by the Office regarding the approval of, or need for revisions to, the Facility Management Standards.

3. Upon approval by the Office of the Facility Management Standards, licensees shall post the Facility Management Standards in a conspicuous place at the aeronautical facility. Licensees shall provide copies of the approved Facility Management Standards to tenants and those others engaged in aeronautical activities at the facility. Licensees shall make copies available to other users of the facility.

4. Revisions to Facility Management Standards which are required because of changes in aeronautical activities must be submitted to the Office in accordance with (c)1 above, within 90 days of any such change.*

(d) Licensees shall enforce the approved and posted *[Aeronautical Activity]* ***General Operating Rules and Facility Management*** Standards.

(e) Compliance with these *[Aeronautical Activity]* ***Facility Management*** Standards shall not relieve the operator of any aeronautical activity from the responsibility to comply with other regulatory requirements.

[(f) Licensees shall establish written aeronautical facility General Operating Rules to ensure the public safety, the safety of the general flying public, and the safety of those using the aeronautical facility. Licensees shall submit their proposed rules to the Director for review and approval. Upon approval, the licensee shall distribute the General Operating Rules to all tenants and make the rules available to other users. In addition, the licensee shall post the rules in conspicuous places at the aeronautical facility.]

*[(g)]***(f)* Public use telephones or other means of communication must be available at all times for emergency service notification (fire, police, rescue) and for contact with FAA air traffic facilities. Emergency phone numbers or notification procedures shall be conspicuously posted.

16:54-3.3 General requirements for restricted use aeronautical facilities

(a) Restricted use ***aeronautical*** facilities shall not be open to general public use and shall not be utilized, advertised, or represented as such.

(b) *[The licensee, or his or her designee]* ***Licensees, or their designees***, shall be responsible for approving the use ***into or out*** of the ***aeronautical*** facility ***for aircraft operations*** by ***an*** *[any]* individual. Approved users shall be advised of facility conditions or restrictions which may affect aircraft operations.

(c) *[Aeronatuical]* ***Aeronautical*** activities may be conducted on restricted use ***aeronautical*** facilities only upon written request to, and after concurrence by, the Office. ***For the purposes of land use and zoning, aeronautical activities are considered a conditional use at restricted use aeronautical facilities.***

(d) Licensees shall establish ***and enforce*** written *[Aeronautical Activity]* ***Facility Management*** Standards for the management and control of all aeronautical activities authorized to be conducted at their aeronautical facility. Such *[standards]* ***Standards*** shall be prepared in accordance with the provisions of N.J.A.C. 16:54-3.2.

(e) Licensees may establish written aeronautical facility *[general operating rules]* ***General Operating Rules*** in accordance with the provisions of N.J.A.C. 16:54-3.2*[(d)]*.

(f) Restricted use aeronautical facilities which require multiple auxiliary sites shall meet the requirements of N.J.A.C. 16:54-2 for each site, unless such requirements are waived in accordance with N.J.A.C. 16:54-2.1(b). Each approved auxiliary site will be listed on the facility license.

16:54-3.4 General requirements for special use ***aeronautical*** facilities

(a) Special use ***aeronautical*** *[facilties]* ***facilities*** shall be available only to those persons specifically listed on the license***,*** *[and]* using only that equipment specifically *[designated]* ***listed*** on the license ***and meeting FAA certificated aircraft operating performance manual standards and limitations***.

[(b) Those persons approved to use the facility shall hold, at a minimum, a current FAA Private Pilot certificate with the applicable category, class, and type rating.]

*[(c)]****(b)*** Applicants for***, and proposed users of,*** a special use ***aeronautical*** facility may be required to conduct a flight demonstration, at a licensed public use aeronautical facility, to satisfactorily demonstrate *[his]* ***their*** ability to operate in a space of like dimensions to that proposed in the application.

*[(d)]****(c)*** Aeronautical activities shall not be permitted at these facilities, except when specifically authorized by the license.

*[(e)]****(d)*** Special use ***aeronautical*** facilities which require multiple auxiliary sites *[will]* ***shall*** meet the requirements of N.J.A.C. 16:54-2 for each site, unless such requirements are waived *[by the Director]* ***in accordance with N.J.A.C. 16:54-2.1(b)***. Each approved auxiliary site will be listed on the facility license.

16:54-3.5 General requirements for aerospace facilities (Reserved)

SUBCHAPTER 4. DESIGN STANDARDS

16:54-4.1 General design standards for all facilities

All licensed and proposed aeronautical facilities shall be designed, constructed, and maintained in accordance with the provisions of N.J.A.C. 16:54-4.2, 4.3, and 4.4, in order to provide for the public safety, the safety of those participating in aviation, and the safety of those using the aeronautical facility.

16:54-4.2 General design standards for public use ***aeronautical*** facilities

(a) Each proposed or licensed public use aeronautical facility shall meet or exceed the minimum standards *[as]* specified for the respective type of aeronautical facility.

1. Public use airport (land or water):

i. Public use airports (land) shall have an effective runway length of 1,800 feet (550 meters) and a runway width of 50 feet (15 meters). Public use airports (water) shall have an effective runway length of 3,900 feet (1,200 meters) and a runway width of 250 feet (76 meters). ***Effective runway length is reduced by 20 percent for each one percent of longitudinal gradient in excess of two percent.*** Additional length and width requirements will be as recommended in FAA Advisory Circular 150/5300-13, as may be revised.

ii. Runway safety areas shall be as recommended in FAA Advisory Circular 150/5300-12 as may be revised.

iii. Each runway will have protected airspace consistent with its intended use, as determined by criteria described in *[FAA]* ***FAR*** Part 77, N.J.A.C. 16:62***,*** and FAA Advisory Circular 150/5300-13, to provide obstacle free aircraft operating areas. This ***protection*** includes clear zones, runway protection zones, side slopes, and transitional surfaces. A minimum approach slope ratio of 20:1 is required.

iv. Operational lighting systems are required for airports operating during hours of darkness. Minimum airport lighting will consist of runway lights, threshold lights and a lighted wind indicator. Runway lights will be spaced not more than 200 feet apart. Additional lighting and visual aids may be required consistent with airport use. FAA Advisory Circular 150/5340-24, as may be amended, will be used for lighting standards. Water facilities will comply with U.S. Coast Guard and other agencies requirements for lighting of sealanes.

v. Pavement marking will conform to standards of FAA Advisory Circular 150/5340-1, as may be amended, and is mandatory consistent with each runway use classification.

2. Public use heliports:

i. Public use heliports shall be not less than 100 feet by 100 feet or 100 feet in diameter, exclusive of the safety area. This minimum size may limit user access and larger facilities *[should be considered dependent upon]* ***may be required to accommodate*** anticipated aircraft size and activity. FAA Advisory Circular *[150/5340-2]* ***150/5390-2*** will be used in designing heliports.

ii. Imaginary surfaces and approach/departure paths will provide protected airspace for two *[ingrees/egrees]* ***ingress/egress*** routes of not less than an 8:1 ratio.

iii. Lighting and visual aids are required for operation during hours of darkness and shall, at a minimum, *[provide]* ***include*** perimeter lighting and a lighted wind indicator. FAA Advisory Circular *[150/5340-2]* ***150/5390-2*** will be used in determining the extent and location of lighting systems.

iv. Heliport marking will be as required in FAA Advisory Circular *[150/5340-2]* ***150/5390-2***, as may be amended.

3. Public use vertiports:

i. Vertiports shall be not less than 250 feet by 250 feet and shall comply with the criteria of FAA Advisory Circular *[150/5340-3]* ***150/5390-3***, as may be amended.

ii. Lighting and visual aids are required for operation during the hours of darkness.

iii. Vertiport surface markings shall conform to FAA Advisory Circular *[150/5340-3]* ***150/5390-3*** as may be amended.

4. Public use balloonports:

i. A public use balloonport shall be not less than 200 feet by 200 feet or 200 feet in diameter. Obstruction clearance for departures will be determined for a 1:1 slope ratio.

ii. Night operation of balloons will be conducted in accordance with applicable federal aviation regulations and sufficient lighting should be provided on the ground for safety of operation.

5. Public use airship base:

i. The length of an airship base will not be less than one and one-half times the overall length of the largest airship anticipated to use the facility. This measurement will begin at the mooring mast and extend in the direction of the landing path. A 20:1 obstacle-free approach/departure path will be provided.

ii. Lighting must be provided for night operations. This may consist of a flashing beacon on the mooring mast and adequate floodlighting to assure obstruction avoidance.

6. Parachute drop zone:

i. Public use parachute drop zones shall be not less than 1,800 feet in diameter or 1,800 feet along *[its]* ***the*** sides of essentially square in shape ***the center of which shall be marked by a highly visible center marker***.

ii. Night parachuting activities will comply with applicable *[federal]* ***Federal*** aviation regulations and sufficient ground lighting should be provided to illuminate the center portion of the drop zone.

16:54-4.3 General design standards for restricted use ***aeronautical*** facilities

(a) All restricted use aeronautical facilities shall meet the ***minimum*** design *[requirements set forth in N.J.A.C. 16:54-4.2]* ***standards*** for the *[same]* ***respective*** type of public use aeronautical *[facilities.]* ***facility as set forth below:**

1. Restricted use airports shall meet the standards set forth for public use airports;

2. Restricted use heliports and helistops shall meet the design requirements of FAA Advisory Circular 150/5390-2, as may be amended or superseded;

3. Restricted use vertiports shall meet the design requirements of FAA Advisory Circular 150/5390-3, as may be amended or superseded;

4. Restricted use balloonports shall meet the following design requirements:

i. Consist of a minimum size of 100 feet by 100 feet or 100 feet in diameter;

ii. Maintain a 1:1 obstruction clearance ratio for departures from the balloonport; and

iii. For night operations, provide ground lighting that adequately illuminates the operating area to assure operational safety;

5. Restricted use airship bases shall meet the following design requirements:

i. Consist of a minimum size, the radius of which is equal to one and one-half times the length of the largest airship anticipated to use the facility;

ii. Maintain a 10:1 obstacle free approach and departure path and a 1:1 obstruction clearance ratio for the perimeter of the airship base;

iii. For night operations, provide lighting in accordance with the provisions of N.J.A.C. 16:54-4.2 for public use airship bases;

6. Restricted use parachute drop zones shall meet the following design requirements;

i. Consist of a minimum size, which is not less than 900 feet in diameter or 900 feet on a side if essentially square in shape, the center of which shall be marked by a highly visible center marker;

ii. For night parachuting activities, meet the provisions of N.J.A.C. 16:54-4.2 for public use parachute drop zones.*

[(b) Restricted use heliports and helistops shall meet the design requirements of FAA Advisory Circular 150/5340-2, as may be amended or superseded.]

*[(c)]****(b)*** Waivers or exemptions to specific design criteria may be *[granted]* ***requested*** in accordance with N.J.A.C. 16:54-7.

16:54-4.4 General design standards for special use aeronautical facilities

(a) All special use aeronautical facilities shall meet the ***minimum*** design *[requirements set forth in N.J.A.C. 16:54-4.3]* ***standards*** for the *[same]* ***respective*** type of *[public use]* aeronautical facility *[or shall comply with the provisions of N.J.A.C. 16:54-3.4 and (b) and (c)]* ***as set forth in (a)1 through 6*** below*[.]****:

1. Special use airports shall meet the standards set forth for restricted use airports as set forth in N.J.A.C. 16:54-4.3;

2. Special use heliports and helistops shall meet the design requirements of FAA Advisory Circular 150/5390-2, as may be amended or superseded;

3. Special use vertiports shall meet the design requirements of FAA Advisory Circular 150/5390-3, as may be amended or superseded;

4. Special use balloon ports shall meet the following design requirements;

i. Consist of a minimum size area which has a diameter not less than the height of the inflated balloon including the basket;

ii. Maintain a 1:1 obstruction clearance ratio for departures from the balloonport; and

iii. For night operations, provide ground lighting that adequately illuminates the operating area to assure operational safety;

5. Special use airship bases shall meet the same design requirements set forth for restricted use airship bases; and

6. Special use parachute drop zones shall meet the following design requirements;

i. Consist of a minimum size, which is not less than 500 feet in diameter or 500 feet on a side if essentially square in shape, the center of which shall be identified by a highly visible center marker;

ii. For night parachuting activities, meet the provisions of N.J.A.C. 16:54-4.2 for public use parachute drop zones; and

iii. For exhibitions, when conducted in accordance with the provisions of N.J.A.C. 16:54-5.1(a), the overall size shall not be smaller than 200 feet in diameter.*

(b) If any of the design standards ***for special use aeronautical facilities set forth herein*** cannot be met *[at a special use aeronautical facility]*****,*** the applicant or licensee shall*****:*** *[submit to the Office copies of the aircraft manufacturer's performance data for the specific aircraft proposed for use at the facility]*

***1. Submit to the Office copies of the aircraft manufacturer's performance data, for the specific aircraft proposed for use at the facility, which shows that the aircraft can, in accordance with manufacturer's and FAA standards, safely use the facility;**

2. If requested by the Office, conduct a flight demonstration, at a licensed public use aeronautical facility, in a space of like dimensions to that proposed in the application, and using the aircraft proposed for use at the special use aeronautical facility.*

(c) Special use aeronautical facilities will not be licensed, or approved*[,]* for use by any aircraft whose minimum performance and operating limits do not permit operations within the available dimensions of the facility.

SUBCHAPTER 5. OPERATIONAL STANDARDS

16:54-5.1 General operational standards

(a) Each licensed aeronautical facility shall prepare and maintain at the aeronautical facility, a facility operations manual which includes the following materials:

1. The facility operating hours and hours attended.

2. Emergency operations information:

i. Emergency notification procedures,

ii. Notification list for use in emergencies with telephone numbers for the facility owner(s), the operator, the local fire department, police, ambulance or emergency medical service, nearest New Jersey State Police Barracks, the NJDOT Office of Aviation, the appropriate FAA Flight Standards District Office, and the NTSB,

3. Emergency procedures to be used in the event of:

i. Fire;

ii. Police or security ***activity***;

iii. Rescue or emergency medical service response; and

iv. Aircraft accident or incident reporting

4. Facility inspection procedures;

5. Facility air traffic pattern(s); ***and***

6. Procedures to use in issuing or cancelling NOTAMs*[; and]*****.***

*[7. Minimum airman qualifications as follows:

i. A student pilot certificate is not an acceptable minimum airman qualification;

ii. For demonstration or exhibition use of a facility, an applicable FAA Commerical Pilot certificate is the minimum acceptable airman qualification; and

iii. For a parachute drop zone for parachute exhibitions, parachutists shall hold a U.S. Parachute Association "C" level qualification or better.]*

(b) For the purpose of issuing Notices to Airmen in an emergency, licensees shall additionally delegate NOTAM issuing authority to the Office. This delegation shall be made to the FAA Flight Service Station with jurisdiction for the facility.

(c) ***Reporting of accidents and incidents shall be accomplished as follows:***

1. Licensees or their agents shall report all aircraft accidents *[or incidents]* occurring on *[or contiguous to]* their aeronautical facility, ***and shall report all known aircraft accidents occurring nearby*** as soon as practicable to the local police ***and*** to the Office *[the FAA Flight Standards District Office (FSDO) with jurisdiction, the NTSB, and the nearest State Police Barracks]*.

***2. Licensees or their agents shall notify the Office of any incident which occurs on their aeronautical facility which affects the operational capability of the facility or requires the closure or shutdown of any portion of the facility.**

3. These reporting requirements as outlined in (c)1 and 2 above do not relieve the operator or aircrew of any aircraft involved in an accident or incident from any responsibility to comply with notification provisions of FAA, State or NTSB regulations.*

[(d) Licensees of all aeronautical facilities shall notify the Office of any proposed changes to air traffic flight patterns for their facility prior to submitting notification to the FAA in accordance with Federal Air Regulation Part 157. The licensee shall receive concurrence from the Office prior to implementing the proposed change.]

***(d) Aeronautical facility air traffic patterns shall be established in accordance with the following procedures:**

1. Licensees shall have all aeronautical facility air traffic flight patterns approved by both the FAA in accordance with FAR 157, and by the Office.

2. Licensees of any aeronautical facility who wish to change the air traffic flight patterns shall concurrently submit to the Office and to the FAA, the proposed changes in accordance with FAA Regulation Part 157.

i. The Office will evaluate the proposal, consider input from the appropriate governing body of the affected municipality(ies), and will either approve, modify, or reject the proposal. Airspace or safety factors will prevail over other considerations.

ii. The Office decision will be forwarded to the FAA for use in the FAR 157 air traffic flight pattern determination.

iii. Aeronautical facilities may not implement any proposed air traffic flight pattern change until it has been approved by the Office and by the FAA.*

(e) Licensees may establish noise abatement procedures for their facility*[.]* ***as follows:*** *[Any proposed procedure or change to existing procedure shall be submitted to the Office for review, coordination with the affected municipality(ies), and approval by the Director prior to implementation.]*

***1. Any proposed noise abatement procedure or change to an existing noise abatement procedure shall be submitted to the Office for review, and consideration of input from the appropriate governing body of the affected municipality(ies).**

2. Noise abatement procedures may not be implemented until they have been approved by the Office.

3. Any proposed noise abatement procedure which requires FAA approval must be approved by the FAA and by the Office prior to being implemented.*

16:54-5.2 Operational standards for public use aeronautical facilities

(a) All public use aeronautical facilities shall maintain a facility operations manual as required by N.J.A.C. 16:54-5.1(a), with the following additions:

1. An aeronautical facility self-inspection program plan which includes:

i. A checklist of items to be inspected;

ii. A schedule of such inspections;

iii. Notification procedures for discrepancies found; and

iv. Corrective action procedures for discrepancies found;

2. Procedures for the control and use of vehicles on the aeronautical operations area;

3. Winter operations snow and ice control plans;

4. Aircraft recovery plan which includes:

i. Procedures to be used in recovering damaged aircraft located on or near the facility;

ii. A list of recovery equipment and sources of that equipment including telephone contacts; and

iii. A list of firms capable of accomplishing such recovery;

5. A listing of aeronautical activities conducted at the facility, along with a copy of the approved Aeronautical Activity Standards for the facility; and

6. A copy of the approved general operating rules for the facility, as required by N.J.A.C. 16:54-3.2(d).

(b) Licensees of public use aeronautical facilities shall prepare aeronautical operations area ground operating procedures which shall be used by all facility users. Such procedures shall be made a part of the facility general operating rules as required by N.J.A.C. 16:54-3.2.

(c) The Director may require noise abatement procedures to be prepared for a public use aeronautical facility, in accordance with N.J.A.C. *[16:54-5.1(d)]* ***16:54-5.1(e)***, in the interest of good community relations. Communities which believe they are adversely impacted by aircraft noise from adjacent public use aeronautical facilities may request the Director to take such action. ***When such notice is received from the appropriate governing body of an impacted municipality, the Director will require the licensee to prepare noise abatement procedures.***

(d) The licensee of each public use aeronautical facility shall enforce the aeronautical facility's approved general operating rules as required in N.J.A.C. 16:54-3.2(d).

[(e) Any use of a public use aeronautical facility which is in violation of the aeronautical facility's approved aeronautical activity standards or the facility's approved general operating rules shall be considered an unlawful use of the aeronautical facility.]

*[(f)]*** ***(e)*** Traffic pattern altitudes for ***fixed wing aircraft operations at*** public use *[aeronautical facilities]* airports shall not be less than 1000 feet AGL (above ground level), except where required for operational considerations ***and/or as directed by FAA for airspace, safety, or operational reasons***.

16:54-5.3 Operational standards for restricted aeronautical facilities

(a) All restricted use aeronautical facilities shall maintain a facility operations manual as required by N.J.A.C. 16:54-5.1(a), with the following additions:

1. An aeronautical facility self inspection program plan which includes:

i. A checklist of items to be inspected;

ii. A schedule of such inspections;

iii. Notification procedures for checklist discrepancies found; and

iv. Corrective action procedures, if required, for checklist discrepancies found;

2. Procedures for the control and use of vehicles on the aeronautical operations area;

3. Procedures for approving the use of the facility by an individual;

4. Procedures for advising facility users about the conditions of the facility and any restrictions at the facility which might affect aircraft operations;

5. A listing of aeronautical activities conducted at the facility, along with a copy of the approved aeronautical activity standards for the facility; and

6. A copy of the facility general operating rules, in accordance with N.J.A.C. 16:54-3.3(e), if applicable.

(b) The licensee of each restricted use aeronautical facility which has general operating rules written and approved for the facility in accordance with N.J.A.C. 16:54-3.2(d) shall enforce the aeronautical facility's approved general operating rules.

16:54-5.4 Operational standards for special use aeronautical facilities

The Director may require licensees of special use aeronautical facilities to comply with specific provisions of N.J.A.C. 16:54-5.2 or 5.3, or other operational standards, when necessary to promote the public safety, the safety of the general flying public, or the safety of those using the aeronautical facility.

SUBCHAPTER 6. TEMPORARY AERONAUTICAL FACILITIES

16:54-6.1 Temporary licenses

(a) The Office may issue a temporary aeronautical facility license for a special purpose, at a designated area which normally requires no facility preparation, and for a limited period of time which shall not exceed nine months.

(b) Temporary licenses may be issued for the following facilities:

1. Airship base;
2. *[Balloonsport]* ***Balloonport***;
3. Helistop;
4. Landing strip;
5. Parachute drop zone;
6. Vertiport; or
7. Any other facility as may be designated by the Director.

(c) Temporary licenses issued by the Office shall indicate the following:

1. An expiration date not to exceed nine months after the date of issuance;
2. Delineation of approved operations; and
3. All applicable privileges or limitations specified by the Office.

(d) Extensions of temporary licenses may be granted by the Director for a period not to exceed 90 days. Requests for extension shall be submitted to the Office in writing with an explanation for the request.

(e) A temporary license may be issued for a facility in conjunction with an application for permanent license. *[Such combined requests shall be accompanied by written concurrence of the municipality that

such use is permitted pending administrative processing of the formal application.]* Temporary licenses *[issued under this rule]* shall *[become void]* ***expire***:

1. Upon issuance of a permanent license;

2. If the application for a permanent facility is disapproved by the Department; or

3. *[One year]* ***Three hundred sixty-four days*** from date of issuance*[,]*. ***Such temporary licenses may be reissued*** if the applicant *[fails to pursue]* ***is actively pursuing*** meeting the requirements of this chapter for a permanent license.

16:54-6.2 Application for temporary license

(a) An application for a temporary license shall:

[1. Be prepared in compliance with the requirements for a permanent facility of the same type, if it is being submitted as a combined request for a permanent license;]

*[2.]***1.*** Include Application Form DA-5, Application for Temporary Aeronautical Facility License; *[and]*

2. If submitted as a combined request with an application for a permanent license, be prepared in compliance with the requirements for a permanent facility of the same type; and

3. Be received by the Office at least 10 working days prior to the requested start date***, unless a shorter time period can be justified by the applicant and is approved by the Office***.

(b) Applications shall include:

1. A letter, statement, or certificate from the ***appropriate*** governing body *[having jurisdiction, signed by the mayor (or a specifically delegated representative),]* which states that there is no objection to the issuance of ***the*** temporary license;

2. A sketch which includes sufficient detail to demonstrate that the proposed facility is capable of accepting the operation proposed;

i. For banner towing facilities, include a sketch of the designated drop and *["]*pickup*["]* area which shows the air traffic pattern for pick-up and drop of the banner.

ii. For parachute drop zones for parachuting exhibitions, the sketch shall include at least a 200 foot by 200 foot clear target/touchdown area and all obstacles and terrain within 1,000 feet of the center of the target/touchdown area;

3. Certification that the areas to be utilized are under the control of the applicant or are being used with the permission of the landowner;

4. A description of the provisions to be made for the safety of those persons in the immediate vicinity of the operation and those participating in the operations;

5. The name, address, and phone number of the person responsible for the conduct of operations at the proposed facility;

6. Aircraft specifications and performance data indicating that the intended operations can be safely conducted in the areas intended for use; and

7. A list of airmen and other persons intending to utilize the facility and their qualifications.

(c) Requests for waivers of application requirements for a temporary facility shall follow the procedures in N.J.A.C. 16:54-2.1(b).

(d) A complete copy of the application and all attachments shall constitute the temporary facility record.

(e) A temporary license may be issued for a facility in conjunction with an application for permanent license. Such combined requests shall include a written notice from the appropriate governing body that it has no objection to the operation of the temporary facility pending processing of the application for a permanent facility.

16:54-6.3 General requirements for temporary aeronautical facilities

(a) The general requirements for temporary ***aeronautical*** facilities which are licensed in conjunction with an application for a permanent license shall substantially meet the requirements for permanent facilities*[,]* as outlined in N.J.A.C. 16:54-3.

(b) Temporary aeronautical facilities which require multiple auxiliary sites shall meet the requirements of N.J.A.C. 16:54-2 for each site, unless such requirements are waived in accordance with the provisions of N.J.A.C. 16:54-2.1(b). Each approved auxiliary site will be listed on the facility license.

16:54-6.4 Design standards for temporary aeronautical facilities

The design standards for temporary facilities which are licensed in conjunction with an application for a permanent license shall substantially meet the requirements for permanent facilities, as outlined in N.J.A.C. 16:54-4.

16:54-6.5 Operational standards for temporary aeronautical facilities

(a) The operational standards for temporary facilities which are licensed in conjunction with an application for a permanent license shall substantially meet the requirements for permanent facilities, as outlined in N.J.A.C. 16:54-5.

(b) The Director may require licensees of temporary facilities not in conjunction with an application for a permanent license to comply with specific provisions of N.J.A.C. 16:54-5.1, 5.2 and 5.3, when necessary to promote the public safety, the safety of the general flying public, or the safety of those using the aeronautical facility.

(c) Minimum airman qualifications for use of a temporary facility are as follows:

1. A student pilot certificate is not an acceptable minimum airman qualification, except for ballooning operations at a temporary balloonport;

2. For demonstration or exhibition use of a facility, an applicable FAA Commercial Pilot certificate is the minimum acceptable airman qualification, except:

i. For ballooning operations which require an applicable FAA Private Pilot certificate; or

ii. For private pilots acting as pilot in command in accordance with all of the provisions of FRA 61.118(d).

3. For a parachute drop zone for parachute exhibitions, a U.S. Parachute Association "C" level qualification is the minimum acceptable qualification.

SUBCHAPTER 7. WAIVERS AND EXEMPTIONS

16:54-7.1 General requirements

(a) Applicants or licensees who believe themselves to be adversely affected by any rule of this chapter, and who believe further that exceptional circumstances or hardship warrant a waiver or exemption from a rule, may petition the Director for relief.

(b) Waivers may be requested if the situation requiring the relief is of a temporary nature.

(c) Exemptions may be requested if the situation requiring the relief is of a continuing nature, and which requires permanent or long term relief from a rule.

16:54-7.2 Requests for waiver

(a) Requests for waiver regarding design criteria or facility requirements shall include:

1. A letter marked "Request for Waiver" which states the specific rule from which relief is being requested, along with a complete description of, and reasons for the request;

2. An attached drawing of the facility or appropriate section thereof, which shows the area involved in the request;

3. An attachment, if appropriate, explaining what measures or alternatives will be used to meet the intent of the rule; and

4. An attachment explaining the time period requested for the waiver, and an explanation of how full compliance is planned at the end of the waiver period.

(b) Requests for waiver for matters not covered in (a) above shall include:

1. A letter marked "Request for Waiver" which states the specific rule from which relief is being requested, along with a complete description of, and reasons for the request;

2. An attachment, if appropriate, explaining what measures or alternatives will be used to meet the intent of the rule; and

3. An attachment, explaining the time period requested for the waiver, and an explanation of how full compliance is planned at the end of the waiver period.

16:54-7.3 Petitions for exemption

(a) Petitions for exemption regarding design criteria or other matters for which a Form DA-1 is suitable, shall include:

1. A Form DA-1 with all pertinent attachments as required by N.J.A.C. 16:54-2.1 marked "Petition for Exemption"; and

2. Appropriate attachments which include a complete description of, and reasons for, the proposed exemption, explaining in detail why the rule provisions cannot be met.

(b) Petitions for exemption for matters not covered in (a) above shall include:

1. A letter requesting the exemption marked "Petition for Exemption" and

2. Appropriate attachments which include a complete description of, and reasons for, the proposed exemption, explaining in detail why the rule provisions cannot be met.

16:54-7.4 Filing, decisions, and appeals

(a) Requests for waivers and petitions for exemption shall be filed with the Director. The Director will review the petition and may approve, reject, or modify the exemption.

(b) Rejected requests or petitions which will result in license denial, modification, suspension, or revocation, may be appealed in accordance with the provisions of N.J.A.C. 16:54-9.3.

SUBCHAPTER 8. LIABILITY AND PENALTY

16:54-8.1 Compliance with laws, rules and regulations

Issuance of a license does not relieve *[the licensee]* ***licensees*** of ***their responsibility to comply with*** any other applicable federal, state, or local laws, rules or regulations.

16:54-8.2 License action

Any license issued pursuant to the provisions set forth in this chapter may be modified, suspended, or revoked in the interest of public safety or as a result of a violation of ***the terms of the license and/or*** any of the provisions of this chapter and/or any of the provisions of N.J.S.A. 6:1-1 et seq. or the rules promulgated thereunder.

16:54-8.3 Misrepresentation or false statement

(a) Any person who makes a misrepresentation or false statement in any application, interview, or submission of information to the Office, shall be considered to be acting contrary to the provisions of this chapter and Title 6 of the New Jersey statutes.

(b) Any application which is found to contain misrepresentations or false statements shall be rejected, and any license issued as a result of that application shall be *[immediately]* suspended, ***unless the Commissioner determines that public health, safety, or welfare requires that the aeronautical facility license should not be suspended*** pending submission of a corrected application. *[If corrections are not made]* ***Corrections to such applications shall be made*** within 30 days, ***or*** the *[Director]* ***Commissioner*** may ***then suspend, extend the suspension of, or*** revoke the license.

16:54-8.4 Actions contrary to the rules

Any person who allows, permits, or otherwise knowingly aids and abets the unlicensed or improperly licensed operation of an aeronautical facility, or who allows, permits, or otherwise knowingly aids and abets any other activities, actions, or conditions that are contrary to the requirements of this chapter or N.J.S.A. 6:1-1 et seq. shall be considered to be *[acting contrary to the provisions of this chapter and shall be considered]* in violation of the chapter.

16:54-8.5 Penalties for violations

(a) Any person violating any provision of N.J.S.A. 6:1-1 et seq. or these rules shall be subject to a penalty of up to $1,000 for each violation, in accordance with N.J.S.A. 6:1-59.1.

(b) Any person who operates, conducts, uses, or permits others to operate, conduct, use or employ any aeronautical facility, operation, or activity which is required to be licensed, without such license being issued or renewed as required by this chapter shall be liable to a penalty of up to $1,000 for each violation, in accordance with N.J.S.A. 6:1-59.1.

SUBCHAPTER 9. SUSPENSIONS AND REVOCATIONS

16:54-9.1 Suspensions

(a) Any license issued pursuant to this chapter may be suspended ***for a period not to exceed 90 days*** when, in the interest of public safety or the safety of those participating in aeronautical activities, the Office determines that a violation of ***the terms of the license and/or*** this chapter has occurred; or a hazard exists which threatens the safety of the general public or those participating in aeronautical activities.

(b) Any aeronautical inspector or *[designated representative of the Commissioner]* ***other personnel identified in N.J.A.C. 16:60-1.3 as law enforcement officers*** may immediately suspend an aeronautical facility license when they deem it necessary to ensure the safety of the general public or those participating in aeronautical activities.

(c) The Office shall notify the licensee of suspension action immediately by the most expeditious means and shall confirm such notice in writing.

(d) Licensees may appeal suspension actions, pursuant to N.J.A.C. 16:54-9.3.

(e) Aeronautical facility licenses which have been suspended shall have the cause abated within the suspension period. Facilities which have not had corrections made during the suspension period shall be presented to the Director, who may extend the suspension or may begin action to revoke the license.

(f) The Director may *[conduct a hearing]* ***hold a conference*** concerning any license suspension action, either when requested by the licensee or by the Department.

16:54-9.2 Revocations; appeal of revocation

(a) The Director is authorized to revoke any suspended Aeronautical Facility License when it is determined that it is in the best interest of public safety or the safety of those participating in aeronautical activities.

(b) Licensees shall be notified by the Office, in writing, of the Department's suspension action pending revocation. *[The licensee shall have 10 days after receipt of such notice to appeal the action in accordance with N.J.A.C. 16:54-9.3.]* If no appeal is filed within *[that]* ***the*** time period ***specified in N.J.A.C. 16:54-9.3***, the license shall be revoked.

(c) Licenses which have been revoked shall not be reinstated. Applicants, including former licensees, shall submit a complete application package for any facility whose license has been revoked.

16:54-9.3 Appeals; generally

(a) Licensees who have had their petition for an exemption denied, their license suspended, or suspended pending revocation, or applicants who have their application for license denied, may *[appeal]* ***seek reconsideration of*** the action to the Director for relief. *[Appeals]* ***Requests for reconsideration*** shall be submitted in writing to the Director within 20 days of notification of the action *[being appealed]*.

(b) The Director, within 20 days of receipt of *[an appeal, shall]* ***a request for reconsideration will***:

1. Conduct *[an informal hearing;]* ***a conference with the licensee.***

2. *[Uphold the appeal and rescind]* ***Rescind*** the action; or

3. Modify the action; or

4. *[Deny the appeal]* ***Sustain the action***.

(c) An appeal from the Director's determination can be made before the Office of Administrative Law (OAL) pursuant to N.J.S.A. *[54:14(b)-1]* ***54:14B-1*** et seq., and N.J.A.C. 1:1. If the applicant determines to appeal, the New Jersey Department of Transportation must be notified by certified mail within 14 calendar days from the applicant's receipt of this Notice of Denial of Permit Application that the applicant is appealing to OAL.

SUBCHAPTER 10. POWERS

16:54-10.1 Authority

Licensing requirements shall not be construed as limiting in any way the power of the Commissioner in regulating the operation of

any aeronautical facilities. Decisions regarding denial, issuance, renewal, suspension, or revocation of licenses are within the purview of, and shall ultimately be determined by, the Commissioner.

APPENDIX A
PUBLIC NOTICE

Notice of Proposed Aeronautical Facility Licensing

ALL INTERESTED PERSONS are hereby advised that the Office of Aviation, of the New Jersey Department of Transportation, has received an application from _____ for a license to establish a _____ at _____.

Accordingly, the Office of Aviation invites written comments or objections regarding this proposed license. All comments or objections must address the issue of the effect of the proposed license upon the public health and safety.

Upon receipt of written comments or objections, and a determination by the Office of Aviation that the proposed licensing is a "contested case", as defined by N.J.S.A. 52:14B-1 et seq., this matter may be scheduled for a public hearing.

The above-named application and all related documents are available for public inspection by appointment between the hours of 9:00 A.M. and 4:00 P.M. at the Office of Aviation, New Jersey Department of Transportation, 1035 Parkway Avenue, Trenton, New Jersey. Telephone (609) 530-2908.

Any interested persons may submit questions or comments, in writing, no later than 30 days from today.

All submissions regarding this matter should be directed to:

Office of Community Involvement
New Jersey Department of Transportation
1035 Parkway Avenue, CN 600
Trenton, New Jersey 08625

NOTES

EMERGENCY ADOPTION

INSURANCE

(a)

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Adopted Emergency New Rules and Concurrent Proposed New Rules: N.J.A.C. 11:20 and Appendices

Emergency New Rules Adopted and Concurrent Proposed New Rules Authorized: June 9, 1993 by the New Jersey Individual Health Coverage Program Board, Charles Wowkanech, Chair.

Gubernatorial Approval (see N.J.S.A. 52:14B-4(c)): June 11, 1993.

Emergency New Rules Filed: June 14, 1993 as R.1993 d.344.

Authority: N.J.S.A. 17B:27A-2 et seq.

Concurrent Proposal Number: PRN 1993-383.

Effective Date: June 14, 1993.

Expiration Date: August 13, 1993.

Submit written comments by August 4, 1993 to:

Interim Administrator
New Jersey Individual Health Coverage Program
c/o The Prudential Insurance Co. of America
P.O. Box 4080
Iselin, NJ 08830

These new rules were adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(c) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of these emergency new rules are being proposed for readoption in compliance with the normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted rules become effective upon the acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed on or before the emergency expiration date.

The agency emergency adoption and concurrent proposal follows:

Summary

These rules are being emergency adopted and concurrently proposed pursuant to the Individual Health Insurance Reform Act, P.L. 1992 c.161 ("Chapter 161") enacted November 30, 1992 (N.J.S.A. 17B:27A-2 et seq.). In accordance with Chapter 161, insurers, health service corporations and health maintenance organizations (collectively, "carriers") must offer individual health benefits plans promulgated by the Individual Health Coverage Program ("IHC Program") Board of Directors ("Board") on a guaranteed issue, community rated basis to New Jersey residents, and/or pay assessments to cover the losses incurred, if any, under such health benefits plans by carriers that do offer the health benefits plans. Failure to comply with the requirements of Chapter 161 may result in a carrier losing its authority to write any health benefits plans in New Jersey.

The Board is given broad powers to oversee the program including authority to define the provisions of individual health benefits plans in accordance with Chapter 161; to review rate and form filings and related data; to grant exemptions from participation to carriers that meet criteria set forth in Chapter 161; and to assess carriers their proportional share of program losses and administrative expenses. These rules implement certain provisions of the program which are necessary in order to begin marketing coverage under the program as of July 1, 1993.

Summaries of the contents of each subchapter are set forth below:

Subchapter 1 sets forth the general purpose of Chapter 20, as well as its scope of applicability. This subchapter sets forth general definitions used throughout Chapter 20. (Additional definitions specific to a subchapter are set forth within the separate subchapter.) Additionally, subchapter 1 includes provisions of overall applicability to carriers or to the general chapter.

Subchapter 2 is reserved.

Subchapter 3 establishes standard benefit levels of the individual health benefits plans to be offered as required under Chapter 161. This subchapter also establishes standard policy forms for individual health benefits policies delivered or issued for delivery in this State on or after the effective date and in accordance with Chapter 161. This subchapter also establishes a transitional period during which a carrier may utilize alternative policy forms and sets forth the filing requirements and review procedures to be utilized by the Board.

Subchapter 4 establishes standard application forms to be used in conjunction with all individual health benefits plans policy forms issued in conjunction with Chapter 161. This subchapter also sets forth procedures for carriers to file alternative application forms, and includes a review provision to be utilized by the Board.

Subchapter 5 establishes a standard claim form that all carriers, to the extent the carrier utilizes claim forms, must use in conjunction with claims arising pursuant to individual health benefits plans policies sold in accordance with Chapter 161.

N.J.S.A. 17B:27A-9(c) requires carriers, prior to issuing new individual health benefits plans policy forms, to first file with the Board an informational filing containing a full schedule of rates. N.J.S.A. 17B:27A-9(d) requires carriers to file with the Board any change in their rates prior to the effective date of the rates. Subchapter 6 specifically sets forth the informational rate filing requirements and procedures as mandated by Chapter 161.

N.J.S.A. 17B:27A-9e(1) requires that contracts or policies for a standard health benefits plan be rated so that the anticipated minimum loss ratio will not be less than 75 percent of the premium. Carriers are required to submit with their rate filing supporting data and a certification that they are in compliance with this requirement. N.J.S.A. 17B:27A-9e(2) provides that carriers whose loss ratios are less than 75 percent for the preceding calendar year will be required to refund to policy or contract holders the difference between the amount of net earned premium received that year and the amount that would have been necessary to achieve the 75 percent loss ratio. Subchapter 7 sets forth the loss ratio reporting requirements and makes it an obligation of carriers not meeting the 75 percent loss ratio to submit for approval a plan for making prompt refunds to policy and contract holders. A Loss Ratio Report Form is provided in the Appendix.

Subchapter 8 establishes reporting requirements which will enable the IHC Program Board to determine a carrier's market share and total number of covered non-group lives for purposes of allocating among carriers assessments for reimbursements of losses, as well as appropriate exemptions criteria in accordance with N.J.S.A. 17B:27A-12a(1)(a) and 12 d. Further, subchapter 8 establishes reporting requirements for carriers claiming reimbursable losses (for which assessments may be made) in accordance with N.J.S.A. 17B:27A-12a(1)(b). Additionally, subchapter 8 sets forth loss reporting criteria for specific losses incurred in calendar year 1992, as required by N.J.S.A. 17B:27A-13. A Market Share and Loss Report Form is provided in the Appendix.

Subchapter 9 sets forth the procedures and standards for applying for and retaining an exemption from assessments for reimbursements of losses pursuant to N.J.S.A. 17B:27A-12d.

Social Impact

These rules implement the Individual Health Coverage Reform Act which established the IHC Program under which all insurance companies, health services corporations and health maintenance organizations that issue or have in force health benefits plans in New Jersey must offer standard health benefits plans and/or pay assessments for losses incurred by other carriers that do offer the plans.

The Board believes that in implementing Chapter 161 by these rules, individual New Jerseyans will have a greater variety of carriers offering individual health insurance coverage in the State. The requirement that carriers offer only the health benefits plans designed by the IHC Program Board should enable individuals to readily compare coverage between carriers, and provides assurances that carriers are offering uniform benefits. Carriers in the market, which are obligated to provide individual health benefits plans on a guaranteed issue, community rated basis, will, as members of the Program, be able to provide for the equitable sharing of losses among all members of the Program.

Economic Impact

These rules will have a substantial economic impact on carriers that offer individual health benefits plans in this State. Member carriers will be required to bear the costs associated with conforming their present business practices to offer the standard health benefits plans set forth in these rules, to make various filings with the Board, and to pay assessments to the Board. The costs will vary among carriers, and member carriers may be required to obtain professional services including actuaries and data systems professionals if such services are not available in-house.

These costs are, however, necessary to implement the comprehensive reforms to the individual health insurance market set forth in Chapter 161. The costs imposed represent the price of these reforms, and the Board believes that the long term benefits to carriers and the public will outweigh the costs.

These rules will not have any substantial economic impact on the State, since Board expenses will be paid through assessments to its members.

Regulatory Flexibility Statement

These rules impose additional recordkeeping, reporting and compliance requirements, as described in the Summary above, for many carriers. The impact will vary among member carriers in accordance with their current practice, but all carriers subject to the rules set forth in this chapter will incur additional costs of compliance.

The Board does not believe that any carriers required to comply with these rules are "small businesses" as that term is defined at N.J.S.A. 52:14B-16 et seq., and therefore no regulatory flexibility analysis is required. Assuming one or more carriers were small busineses, however, the Board would not be inclined to include any relaxation of these rules, or different compliance requirements, for small businesses. The underlying legislation is intended to establish a limited number of standard health benefits plans for individuals, and to provide a method for regulating individual health benefits plans in a uniform manner. Different rules applicable to small business carriers would be inconsistent with this clearly stated legislative goal.

Full text of the emergency adopted and concurrent proposed new rules follows:

CHAPTER 20
INDIVIDUAL HEALTH COVERAGE PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

11:20-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.), the Individual Health Insurance Reform Act. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-2 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Individual Health Coverage Program pursuant to N.J.S.A. 17B:27A-2 et seq.

(b) Provisions of the New Jersey Individual Health Insurance Reform Act and of this chapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Individual Health Insurance Reform Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after November 30, 1992, except as the specific provisions of the statute and of this chapter state otherwise.

11:20-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

"Act" means the Individual Health Insurance Reform Act, P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 through 16).

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another.

"Board" means the Board of Directors of the New Jersey Individual Health Coverage Program established by the Act.

"Carrier" means an insurance company, health service corporation or health maintenance organization authorized to issue health benefits plans in New Jersey. Carriers that are affiliated carriers shall be treated as one carrier.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, without regard to age, sex, health status, occupation and geographical location.

"Conversion health benefits plan" means a group conversion contract or policy issued on or after November 30, 1992 in which no set portion or part of the premium for the contract or policy is charged to, or subsidized by, the group policy from which the conversion is made.

"Department" means the New Jersey Department of Insurance.

"Dependent" means the spouse or child of an eligible person, subject to applicable terms of the individual health benefits plan.

"Eligible person" means a person who is a resident of this State who is not eligible to be insured under a group health benefits plan, Medicare or Medicaid.

"Expenses" means a carrier's actual expenses including commissions to licensed insurance producers calculated on an incurred statutory basis and allocated on a consistent basis to individual lines, or a maximum of 25 percent of premium, whichever amount is less.

"Family unit" means a legally married man and woman and their dependent child(ren) living in the same household or a single person and his or her dependent child(ren) living in the same household.

"Federally-qualified HMO" is a health maintenance organization which is qualified pursuant to the "Health Maintenance Organization Act of 1973," Pub. L. 93-222 (42 U.S.C. §300e et seq.).

"Group health benefits plan" means a health benefits plan for groups of two or more persons.

"Health benefits plan" means a hospital and medical expense insurance policy, including certificates covering individual New Jersey residents, a health service corporation subscriber contract or a health maintenance organization enrollment contract delivered or issued for delivery in New Jersey. The term "health benefits plan" specifically includes:

1. Standard health benefits plans as defined in this section;
2. Closed blocks of business otherwise meeting the definition of health benefits plan;
3. Executive medical plans;
4. Student coverage which provides more than accident-only coverages;
5. All prescription drug plans whether or not written on a stand alone basis;
6. Plans that cover both active employees and retirees eligible for Medicare for which separate statutory reporting is not made by the carrier; and
7. All other health policies, plans or contracts not specifically excluded.

The term "health benefits plan" specifically excludes:

1. Accident-only coverage;
2. Credit insurance;
3. Disability insurance;
4. Long-term care coverage;
5. Coverage arising out of a worker's compensation or similar law;
6. Automobile medical payment insurance or personal injury protection insurance issued pursuant to N.J.S.A. 39:6A-1 et seq.;
7. Medical coverage provided as part of a liability policy;
8. Medical coverage provided as a rider to a non-medical benefits plan, wherein the medical coverage constitutes less than five percent of the premium for the benefits plan, including riders, and therefore is an incidental part of the benefits plan's coverage;
9. Hospital confinement indemnity coverage so long as the coverage is provided on a stand alone basis, contains no elimination period greater than three days, provides coverage for no less than 31 days during one period of confinement for each person covered under the policy, and provides no less than $40.00 but no more than $250.00 in daily benefits;

10. Dental plans, whether or not written on a stand alone basis;
11. Vision care plans, whether or not written on a stand alone basis;
12. Reinsurance;
13. Coverage for Medicaid services provided pursuant to a contract with the State of New Jersey;
14. Medicare risk and cost contracts as defined in this section;
15. Coverage which is specifically advertised, marketed and designed to supplement CHAMPUS;
16. Medicare supplement coverage to the extent that such coverage meets the requirements of N.J.A.C. 11:4-23, Minimum Standards for Medicare Supplement Coverage, and is coverage that is reported on the Medicare Supplement Insurance Experience Exhibit of the NAIC Annual Statement blank for Life and Accident and Health Insurance or Health Maintenance Organizations; and
17. Self insured arrangements for which revenue is not included as premium for statutory reporting purposes.

"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, s.25 (N.J.S.A. 26:2H-18.47).

"IHC Program" means the New Jersey Individual Health Coverage Program.

"Individual health benefits plan" means a health benefits plan for eligible persons and their dependents.

"Informational filing" means a submission by a carrier of rate manuals which specify the plans offered, premium rates, all factors to be used in the calculation of premium rates, and a detailed actuarial memorandum supporting the calculation of the rates, a certification by a member of the American Academy of Actuaries, all supporting data for the premium rates and such other information as the Board from time to time requests or requires.

"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.

"Medicare" means coverage provided pursuant to Title XVIII of the Federal Social Security Act, Pub. L. 89-97 (42 U.S.C. §1395 et seq.) and amendments thereto.

"Medicare cost and risk contracts" means policies or contracts issued by carriers pursuant to a contract between the carrier and the Federal government under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.) and amendments thereto.

"Member" means a carrier that issues or has in force health benefits plans.

"Modified community rated" means that the premium for all persons covered under a health benefits plan contract is formulated based on the experience of all persons covered by that contract, without regard to age, sex, occupation and geographical location, but with differentiation by health status.

"NAIC" means the National Association of Insurance Commissioners.

"Net earned premium" means the premiums 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 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-insured arrangements to reimburse only the self-insured arrangement 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.

"Non-group persons" include individually enrolled persons, persons covered by conversion policies issued pursuant to the Act, Medicare cost and risk lives and Medicaid and HealthStart Plus recipients.

"Open enrollment" means the continuous offering of a health benefits plan to any eligible person on a guaranteed issue basis.

"Pre-existing condition" means a condition that, during a specified period of not more than six months immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a pregnancy existing on the effective date of coverage.

"Premium earned" means premium received, adjusted for the changes in premium due and unpaid, and paid in advance, and unearned premium, net of refunds or dividends paid or credited to policyholders, but not reduced by dividends to stockholders or by active life reserves.

"Program" means the New Jersey Individual Health Coverage Program established pursuant to the Act.

"Public Advocate" means the New Jersey Department of the Public Advocate, Division of Rate Counsel.

"Reasonable and customary" means the 80th percentile of the Prevailing Healthcare Charges System (PHCS) profile for New Jersey for various medical services and supplies, published and available from the Health Insurance Association of America.

"Reimbursement for losses" means reimbursements distributed through the IHC Program to cover losses, in whole or in part, incurred by members applying for reimbursements with respect to individual standard health benefits plans beginning in calendar year 1993 and thereafter.

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

"Standard health benefits plan" means a health benefit plan, including riders, if any, adopted by the IHC Program Board.

11:20-1.3 Closing of noncomplying individual health benefits plans

(a) Carriers may begin to market individual standard health benefits plans as defined at N.J.A.C. 11:20-3 on or after July 1, 1993, but not before; those standard health benefits plans shall not have a coverage effective date prior to August 1, 1993. All coverage under individual health benefits plans delivered or issued for delivery with an effective date of August 1, 1993 or thereafter shall comply with these rules.

(b) Health benefits plans not subject to the Act shall remain subject to the full review and approval of the Commissioner in accordance with N.J.S.A. 17B:26-1 et seq., N.J.S.A. 17:48E-1 et seq., N.J.S.A. 26:2J-1 et seq. and rules promulgated pursuant thereto.

11:20-1.4 Other laws of this State

All health benefits plans delivered or issued for delivery in New Jersey, as defined by this subchapter, including individual standard health benefits plans, shall be subject to the Individual Health Insurance Reform Act, as well as all relevant statutes and rules of New Jersey not inconsistent with, amended or repealed by the Act.

11:20-1.5 Penalties

Failure of a carrier to comply with any provision of this chapter may result in the carrier losing its authority to write health benefits in New Jersey and imposition of any and all penalties and actions available under law.

11:20-1.6 Severability

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

SUBCHAPTER 2. (RESERVED)

SUBCHAPTER 3. STANDARD BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 Benefits provided

(a) The standard individual health benefits plans established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

1. Plan A, "The Basic Health Benefits Plans," Exhibit A, sections III, V, VI, VII and IX;

2. Plan B, "Individual Health Benefits Plan B," Exhibit B, sections III, V, VI, VII and IX;

3. Plan C, "Individual Health Benefits Plan C," Exhibit C, sections III, V, VI, VII and IX;

4. Plan D, "Individual Health Benefits Plan D," Exhibit D, sections III, V, VI, VII and IX;

5. Plan E, "Individual Health Benefits Plan E," Exhibit E, sections III, V, VI, VII and IX; and

6. HMO Plan, "Health Maintenance Organization Benefits Plan," Exhibit F, sections III, V, and VI.

(b) In accordance with N.J.A.C. 11:20-1.3, members that offer individual health benefits plans in this State shall offer standard health benefits Plans A, B, C, D and E as set forth in Exhibits A through E, respectively, in the Appendix.

1. Members offering Plans B, C, and D shall offer the following annual deductible options to the policyholder for each plan:

i. $250.00 per individual and $500.00 per family unit;

ii. $500.00 per individual and $1,000 per family unit;

iii. $1,000 per individual and $2,000 per family unit.

2. Members offering Plan E shall offer the following annual deductible options to the policyholder for this plan:

i. $150.00 per individual and $300.00 per family unit;

ii. $500.00 per individual and $1,000 per family unit;

iii. $1,000 per individual and $2,000 per family unit.

(c) HMO members may offer the HMO Plan, as set forth in Exhibit F of the Appendix, in lieu of Plans A through E in (a) above. HMO members offering the HMO Plan shall offer the following arrangements: $150.00 hospital inpatient copay, $50.00 separate emergency room copay, $15.00 for all other copays. HMO members choosing to offer optional health benefits plans may offer one or both of the following copayment options, provided that all options marketed shall be offered to each applicant:

1. $250.00 hospital inpatient copay, $200.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, $20.00 for all other copays; and/or

2. $100.00 hospital inpatient copay, $100.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, $10.00 for all other copays.

(d) Each of the standard health benefits plans may be offered through or in conjunction with a managed care network, and shall be subject to the following:

1. The in-network and out-network benefit level differential shall not exceed 30 percent;

2. The coinsurance maximum specified for the standard health benefits plan being offered through or in conjunction with a managed care network, as set forth in Exhibits A through E in the Appendix, shall be the coinsurance maximum for the in-network and out-network benefits combined; and

3. The HMO Plan standard copayment level ($15.00) may be substituted for deductibles applicable to in-network benefits.

11:20-3.2 Policy forms

(a) For standard health benefits plans policies effective on or after August 1, 1993, members shall use the standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F, except as provided in (b) below. Before marketing the standard policy forms, a member shall file in triplicate with the Board a certification signed by the Chief Executive Officer of the member that sets forth that the standard policy forms will be used by the member.

(b) As a transitional measure, a member may submit to the Board alternative policy forms for the standard health benefits plans, so long as the alternative policy forms are in substantial compliance with the standard policy forms set forth in the Appendix. These alternative policy forms may be used, except as provided in (b)3 and 4 below, until the next anniversary date at which time the member shall issue a standard policy form in accordance with (a) above.

1. The alternative policy form shall be submitted with a certification of the Chief Executive Officer of the member that the policy form submitted for approval is in substantial compliance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20.

2. Alternative individual health benefits plan policy forms shall be submitted in triplicate to the Board at the following address:

Interim Administrator
Individual Health Coverage Program Board
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, New Jersey 08830

3. Upon filing, a member may use an alternative policy form unless and until it has been disapproved in accordance with this rule.

4. After notice and 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, the Board shall disapprove any proposed alternative policy form that:

i. Is not in substantial compliance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20-3;

ii. Is not substantially compliant with the corresponding standard policy form set forth in the Appendix to this subchapter; and

iii. Does not provide benefit levels that are identical to the benefit levels set forth in the corresponding plan as provided in N.J.A.C. 11:20-3.1.

(c) Notwithstanding the provisions of (a) and (b) above, a member choosing to offer a standard health benefits plan through or in conjunction with a managed care network in accordance with N.J.A.C. 11:20-3.1(d) shall submit alternative policy forms which are consistent with N.J.A.C. 11:20-3.1(d) and the purposes of the Act. Upon filing, a member may use such alternative policy form unless and until it has been disapproved in accordance with this rule. Such forms shall be submitted in accordance with (b)2 above. The alternative policy form shall be submitted with a certification of the Chief Executive Officer of the member that the policy form submitted is in substantial compliance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20. After notice and 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, the Board shall disapprove any such proposed alternative policy form that:

1. Is not in substantial compliance with N.J.S.A. 17B:27A-2 et seq., and this subchapter; or

2. Does not provide benefit levels that are identical to the benefit levels set forth in the corresponding plan as provided in N.J.A.C. 11:20-3.1.

SUBCHAPTER 4. STANDARD APPLICATION FORM

11:20-4.1 Standard application form

(a) All members offering standard health benefits plans with an effective date on or after August 1, 1993, shall use the standard application form approved by the Board and specified in Exhibit G of the Appendix to this chapter, except as provided in (b) below.

(b) A member may submit to the Board for approval an alternative application form that differs in format but not in content from the standard form set forth in Exhibit G of the Appendix. The member may use the alternative form when submitted unless and until disapproved by the Board.

1. The alternative application form shall be submitted with a certification by the Chief Executive Officer of the member that the alternative application form requests only the information specified in the form in Exhibit G of the Appendix.

2. Alternative application forms shall be submitted in triplicate to the Board at the following address:

Interim Administrator
Individual Health Coverage Program Board
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, New Jersey 08830

3. The Board shall disapprove any alternative application form that is not consistent with the purpose of this chapter.

4. If any proposed alternative application form is disapproved, it may not be used with a policy form delivered or issued for delivery unless and until such disapproval is withdrawn.

5. Upon request by the member for a hearing, the Board's disapproval of an alternative application form 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.

SUBCHAPTER 5. STANDARD CLAIM FORM

11:20-5.1 Standard Claim Form

Effective August 1, 1993, all members offering health benefits plans or other health insurance policies to individuals shall, to the extent that the member uses claims forms in its transaction of business, require as a condition of payment, the standard claims form approved by the Board and set forth as Exhibit H in the Appendix to this chapter, incorporated herein by reference. The standard claim form shall be used for all medical expenses incurrecd for services other than hospital inpatient services. Members shall use form UB-82 set forth as Exhibit I in the Appendix to this chapter for hospital inpatient services.

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS CARRIERS INFORMATIONAL RATE FILING REQUIREMENTS

11:20-6.1 Purpose and scope

The purpose of this subchapter is to establish informational rate filing requirements and procedures for members issuing or renewing individual health benefits plans pursuant to section 2b(1) and 3 of the Act (N.J.S.A. 17B:-27A-3b(1) and 17B:27A-4).

11:20-6.2 Informational filing requirements

(a) All members issuing standard health benefits plans or conversion health benefits plans on a new contract or policy form shall make, prior to issuing any standard health benefits plan or conversion benefits plan, an informational filing with the Board, which shall include the following supporting data:

1. Rate manuals specifying the standard health benefits plans offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any factors prohibited by the Act;

2. Premium rates and any factors used in the calculation of the premium rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date, and may be developed on different rate tiers for family units (that is, different community rates for individuals, two-person families and larger families) provided that all proposed rates applicable in this State have been filed with the Board before being used;

3. A detailed actuarial memorandum, which shall include the following:

i. The rates being submitted;

ii. All information used in the development of the rates;

iii. The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including historical experience, trend assumptions, plan relativity assumptions, and any other factors used in developing the anticipated loss experience; and

iv. The administrative expense, premium tax and commission payment assumptions, and other margins;

4. A certification signed by a member of the American Academy of Actuaries, which shall include the following:

i. A statement that the informational filing is complete; and

ii. A statement that the carrier's loss ratio is expected to be at least 75 percent; and

5. Such other information or data as may be required or requested by the Board to analyze the adequacy of the rate filing submitted.

(b) Any member which seeks to change its rates for its standard health benefits plans, conversion health benefits plans, or its community rated and modified community rated health benefits plans issued prior to June 14, 1993 shall, prior to the effective date of the revised rates, submit to the Board an informational filing, which shall include all the supporting data set forth in (a) above.

11:20-6.3 Informational filing procedures

(a) The informational filing filed by the member with the Board pursuant to N.J.A.C. 11:20-6.2(a) or (b) above shall be filed in triplicate as follows:

Interim Administrator
New Jersey Individual Health Coverage Program
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, NJ 08830

(b) If the Board determines that an informational filing filed pursuant to N.J.A.C. 11:20-6.2(a) or (b) above is incomplete, the Board shall provide written notice to the member specifying those portions of the filing which are deficient and the information required to be submitted or resubmitted by the member.

(c) Upon 15 days of receipt of written notice in (b) above, the member shall provide the Board with the information required to complete the filing.

(d) Upon notice that the filing is incomplete, the member shall not use the filed rates until the Board has determined that the informational filing is complete, and written notice of that fact has been provided to the member.

(e) The Board shall, within 15 days of receipt of a member's informational rate filing and within 15 days of receipt of any material submitted or resubmitted by a member at the request of the Board in accordance with (b) above, submit copies of the filing to the Commissioner and to the Public Advocate as follows:

Commissioner of Insurance
ATTN: IHCP Rate Filings
New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, New Jersey 08625-0325

Division of Rate Counsel
Department of the Public Advocate
Hughes Justice Complex
CN-850
Trenton, NJ 08625

SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

11:20-7.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of the Act.

11:20-7.2 Filing of Loss Ratio Report

(a) Each member that had a standard health benefits plan in force during the preceding calendar year shall file with the Board an annual Loss Ratio Report on the form appearing as Exhibit J in the Appendix to this chapter incorporated herein by reference.

(b) The Report shall be filed on the basis of the combined total of the standard health benefits plans policy forms written by the member.

(c) The Report shall be completed and filed with the Board on or before August 15 for the calendar year immediately preceding.

11:20-7.3 Contents of the Loss Ratio Report

(a) A Loss Ratio Report form shall be completed annually by each member and shall include the following information:

1. The reporting member's name and address;
2. The member's net earned premium for standard health benefits plan during the calendar year immediately preceding;
3. A statement of the member's total losses incurred consisting of:
i. Claims incurred during the calendar year and paid through June 30 of the reporting year; plus
ii. Residual reserve consisting of:
(1) Safeharbor reserve (3.3 percent of (a)3i above); or
(2) Calculated residual reserve (supported by actuarial certification); and
iii. A pro rata share of any assessment paid during the period, determined as the member's total assessment multiplied by the net earned premium for standard health benefits plans divided by the net earned premiums for all of the member's health benefits plans;
4. The member's loss ratio (determined by dividing the total losses incurred by the net earned premium as determined in (a)2 above);
5. Certification by a member of the American Academy of Actuaries that the information provided in the Report is accurate, complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-9 in accordance with instructions; and
6. Such other information as the Board may request.

11:20-7.4 Refund plan

If the calendar year loss ratio is less than 75 percent, the member shall include with the Report a plan to be approved by the Board for a prompt refund to policy and contract holders of the difference between the amount of net earned premium it received that year on the standard health benefits plans and the amount that would have been necessary to achieve the 75 percent loss ratio.

11:20-7.5 Confidentiality of documents

All documents submitted to the Board pursuant to this subchapter are confidential and not public documents as defined in the "Right-to-Know" Law, N.J.S.A. 47:1A-1 et seq.

SUBCHAPTER 8. THE IHC PROGRAM MARKET SHARE AND NET PAID LOSS REPORT

11:20-8.1 Scope and applicability

(a) This subchapter sets forth annual reporting requirements of market share data and losses to determine the total amount of losses which are reimbursable, and the allocation of assessments for reimbursement of those losses, as well as a basis for determining criteria to be met by carriers requesting exemption from such assessments.

(b) This subchapter shall apply to all carriers that are or become members of the New Jersey Individual Health Coverage Program for any portion of a calendar year for which reports under this subchapter are required to be filed, whether or not the carrier is a member at the time that the report is to be filed.

11:20-8.2 Filing of the market share and net paid loss report form

(a) Every member of the IHC Program shall file the report form set forth as Exhibit K in the Appendix to this chapter, on or before June 28, 1993 and annually thereafter no later than March 1. Every member shall complete Parts A, B, C and D of the report form, whether or not the member is seeking reimbursements for losses, or exemptions from assessments for losses.

(b) Affiliated carriers shall submit a combined report using the report form set forth as Exhibit K in the Appendix.

1. The combined report form shall be submitted under the name of one of the affiliated carrier's members, and shall include as attachments the separate reports of each of the members of the affiliated carrier including the separate report of the member submitting the combined report form, all as one package.

2. In lieu of a combined report for the filing due June 28, 1993, members of an affiliated carrier may submit their separate report forms with an attachment listing the other members within the affiliated carrier.

(c) Certified report forms shall be submitted by facsimile to the Interim Administrator at (908) 632-7409, or to:

Interim Administrator
New Jersey Individual Health Coverage Program
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, NJ 08830

11:20-8.3 Net earned premium

(a) Every member shall set forth its net earned premium for the preceding calendar year ending December 31 in Part C1 of the report.

1. Net earned premium set forth in Part C1 of the report form shall include net earned premium resulting from group health benefits plans and individual health benefits plans issued, continued or renewed during the preceding calendar year, including premiums from conversion health benefits plans.

2. Net earned premium reported in Part C1 of the report form shall be based upon, if not the same as, the data set forth in the member's annual reports, as follows, adjusted to meet the definitions set forth in this subchapter as necessary:

i. The NAIC Life and Health Blank (Blue), State page 19, entitled "Accident and Health Insurance," Column 3 less Column 4, line 23 plus line 23.2 plus line 24.6;

ii. The NAIC Fire and Casualty Blank (Yellow), State page 14 entitled "Exhibit of Premiums and Losses," Column 3 less Column 4, line 13 plus line 15.1 through line 15.6;

iii. The NAIC HMDI Blank (White), page 6, entitled "Underwriting and Investment Exhibit," Part 1, Line 5, Column 9 less (Column 2 minus Column 3), and less reinsurance portions of (Column 5 minus Column 8);

iv. The New Jersey State HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Lines 1 plus 2 plus 4 plus 5; or

v. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Lines 1 plus 2 plus 3 plus 4.

11:20-8.4 Calculation of covered non-group persons

Members shall report in Part C2 of the report form the total number of persons covered under individual community rated health benefits plans, individual modified community rated health benefits plans, conversion health benefits plans, the number of Medicaid recipients covered by the member under a contract with the State of New Jersey, and Medicare lives covered by the member under Medicare cost and risk contracts with the Federal government, and contracts covering actual HealthStart Plus recipients, as of December 31 of the preceding calendar year.

11:20-8.5 Calculating net paid losses or gains

(a) For purposes of completing Part C3 of the report form, members shall provide data for their individual health benefits plans issued or renewed pursuant to sections 2b(1) or 3 of the Act (N.J.S.A. 17B:27A-3b(1) or (4)), for the preceding calendar year ending December 31.

1. All data shall be for direct business only; reinsurance accepted shall not be included, and reinsurance ceded shall not be deducted.

2. The method used by a member to allocate to sublines of the individual line shall be consistent with the method used by a member to allocate to the individual line.

(b) Premium earned shall be adjusted by any changes in non-admitted premium assets consistent with statutory report requirements, except that any change in non-admitted assets associated with premium accrued shall be reported consistent with the following bases, as appropriate to the member, adjusted for the individual health benefits plan for which the report is being made, as necessary:

1. The NAIC Life and Health Blank (Blue), State page 19 entitled "Accident and Health Insurance," Column 3 less Column 4, line 23.2 plus 24.6;

2. The NAIC Fire and Casualty Blank (Yellow), State page 14, entitled "Exhibit of Premiums and Losses," Column 3 less Column 4, lines 15.1 through 15.6;

3. The NAIC HMDI Blank (White), Exhibit 5, entitled "Underwriting Gains and (Losses) by Enrollment Classification," Column 3, sections 2 plus 3 less Complementary Medicare and less reinsurance;

4. The New Jersey HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Line 1 plus 2 plus 4 plus 5; or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Lines 1 plus 2 plus 3 plus 4.

(c) In reporting claims paid, profits made by affiliated providers of service shall not be included in paid claims. Claims paid shall be reported on a basis consistent with statutory reporting, as is appropriate for the member, adjusted as necessary for the individual health benefits plans for which the report is being made, with the following serving as the basis:

1. The NAIC Life and Health Blank (Blue), State page 19, entitled "Accident and Health Insurance," Column 5, line 23.2 plus line 24.6;

2. The NAIC Fire and Casualty Blank (Yellow), State page 14, entitled "Exhibit of Premiums and Losses," Column 6, lines 15.1 through 15.6;

3. The NAIC HMDI Blank (White), Underwriting and Investment Exhibit, Part 2, Column 2, less reinsurance, adjusted to Individual, less Complementary Medicare and Group;

4. The New Jersey State HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year (Lines 20 minus 7 minus 3 minus 17) less page 31, Report No. 1, Part B, (Column 3, line 2 through 6 less Column 4, lines 2 through 6); or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, (Lines 16 plus 20) less Report No. 1, Part B, ((Column 3, Lines 2 plus 3) minus (Column 4, Lines 2 plus 3)).

(d) Expenses shall reflect current expense items only and shall exclude prior period adjustments as well as excluding surplus adjustments and Federal and State income taxes. Expenses shall include premium taxes and commissions. Expenses shall be reported consistent with the following bases, as appropriate to the member, adjusted for New Jersey, and adjusted for the individual health benefits plans for which the report is being made, as necessary, but in no instance shall expenses exceed 25 percent of premium earned:

1. The NAIC Life and Health Blank (Blue), page 6, entitled "Analysis of Operations by Lines of Business," Column 11, lines 20, 22, and 23 (less State income taxes);

2. The NAIC Fire and Casualty Blank (Yellow), Insurance Expenses Exhibit, Part III, Columns 5, 6, 12, 13, 14, 15, line 15;

3. The NAIC HMDI Blank (White), Exhibit 5, entitled "Underwriting Gains and (Losses) by Enrollment Classification," Column 5, sections 2 plus 3 less Complementary Medicare and less reinsurance;

4. The New Jersey HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Line 26; or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Line 27.

(e) Blue Cross and Blue Shield of New Jersey, Inc. shall report the amount of subsidy approved by the Hospital Rate Setting Commission for its individual line of business in 1992, not including the "fast payor" discount factor included in the 1992 hospital payor differential.

(f) Net investment income shall be calculated in accordance with statutory reporting requirements and allocated on a consistent basis to individual lines, adjusted for State and reinsurance as necessary. The net investment income shall be reported consistent with the following bases, as appropriate to the member, adjusted for the individual health benefits plans for which the report is being made as necessary:

1. The NAIC Life and Health Blank (Blue), page 6, entitled "Analysis of Operations by Lines of Business," Column 11, line 4;

2. The NAIC Fire and Casualty Blank (Yellow), Insurance Expenses Exhibit, Part II, Column 18, line 15;

3. The NAIC HMDI Blank (White), page 4, Column 1, line 7, adjust for individual lines, reinsurance and Complementary Medicare;

4. The New Jersey HMO Annual Statement (for 1992), page 32, Report No. 2, Current Year Line 6; or

5. The NAIC HMO Blank (for 1993 and thereafter), page 4, Report No. 2, Column 2, Line 5.

11:20-8.6 Certification

(a) All reports shall be certified as accurate, complete and conforming with the requirements of this subchapter by the Chief Financial Officer or other duly authorized officer of the member. The person certifying the combined report of an affiliated carrier shall be the same person certifying the separate report of the member submitting the combined report for the affiliated carrier.

(b) Notwithstanding certification of the combined report, the persons certifying the separate reports of the members of the affiliated carrier shall be responsible for any errors contained in the separate member's report.

11:20-8.7 Failure to comply

(a) Failure to comply with the reporting provisions of this subchapter as required by June 28, 1993 shall result in:

1. The denial of a member's application for exemption from assessments for reimbursable losses under the IHC Program for the remainder of calendar year 1993; and

2. The Board determining that the premium set forth in the member's most recent Annual Statement filed with the Department is the premium base upon which that member's market share allocation of assessments for reimbursement of losses will be calculated by the Board.

SUBCHAPTER 9. EXEMPTIONS

11:20-9.1 Purpose

The purpose of this subchapter is to set forth the procedures for obtaining and the standards for granting exemptions from assessments for reimbursement of losses in accordance with N.J.S.A. 17B:27A-12.

11:20-9.2 Filing for an exemption from assessments for reimbursements

(a) A member seeking to be exempted from the obligation to pay assessments for the reimbursement of losses shall submit a written request for such exemption to the Board. A written request for an exemption shall be submitted annually no later than May 1, except that in 1993, written request for exemptions shall be submitted to the Board on or before August 1, 1993. Written requests shall be submitted to:

Interim Administrator
New Jersey Individual Health Coverage Program
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, New Jersey 08830

(b) Written requests for exemptions shall be certified by the Chief Financial Officer, or other duly authorized officer, of the member, and shall include affirmative statements that the member agrees:

1. To enroll or insure the minimum number of non-group persons necessary for the member to meet its minimum enrollment share of non-group persons, allocated to it by the Board pursuant to N.J.A.C. 11:20-93;

2. To enroll or insure the minimum number of non-group persons under:

i. Standard health benefit plans;

ii. Health benefits plans designed to meet the requirements for enrollment of Medicaid recipients and HealthStart Plus recipients, if such health benefits are required to provide coverage not in compliance with the standard health benefits plans, pursuant to N.J.S.A. 30:4D-7b or 7c, or N.J.S.A. 26:2H-18.47, and any rules and regulations promulgated thereunder; and

iii. Medicare cost and risk contracts with the Federal government, with respect to Medicare recipients; and

3. Not to seek reimbursements for losses the member may incur under the standard health benefits plans in that calendar year for which an exemption is sought by the member.

(c) Within 30 days of receipt of the member's written request for an exemption, the Board shall grant the member a conditional exemption, or deny the member's request for an exemption in writing, specifying the reasons for the denial. If the member's written request for an exemption is neither approved nor disapproved within

30 days of its receipt by the Board, the written request shall be deemed to be conditionally approved.

(d) Approval of a member's written request for an exemption is conditioned upon the following:

1. Compliance by the member with N.J.A.C. 11:20-8 and this subchapter;

2. Compliance by the member with (b) above, as appropriate.

11:20-9.3 Minimum enrollment share

(a) On or about July 8, 1993, and annually thereafter on or before April 1, the IHC Program Board shall issue to each member its minimum enrollment share of non-group persons for that calendar year which the member must agree to cover in that calendar year for purposes of obtaining an exemption from assessments for reimbursements for losses incurred in that calendar year.

(b) The IHC Program Board's determination of minimum enrollment shares shall be based upon information provided by members in accordance with N.J.A.C. 11:20-8 and this subchapter.

(c) The minimum number of non-group persons shall be calculated as the total number of community rated and modified community rated, individually enrolled or insured persons, including Medicare cost and risk lives and enrolled Medicaid and HealthStart Plus lives of all carriers subject to the Act as of the end of the preceding calendar year multiplied by the proportion that that carrier's net earned premium bears to the net earned premium of all carriers for the preceding calendar year including those carriers exempt from assessment.

11:20-9.4 Satisfaction of minimum number of non-group persons

(a) Persons counted under the following may be counted by a member in meeting its minimum number of non-group persons:

1. Standard health benefits plans;

2. Conversion policies issued pursuant to the Act;

3. Contracts covering HealthStart Plus recipients; and

4. Medicare cost and risk contracts and contracts with the State of New Jersey covering Medicaid recipients, except that the number of non-group persons covered under these contracts combined shall not exceed 50 percent of the member's total number of non-group persons.

(b) If the member is a Federally-qualified HMO that is tax exempt pursuant to paragraph (3) of subsection (c) of section 501 of the Federal Internal Revenue Code of 1986, 26 U.S.C. 501, the member may count persons covered under (a)1 and (a)4 above, except that in determining whether the member meets its minimum number of non-group persons, the total may include no more than one third Medicare recipients and one third Medicaid recipients.

11:20-9.5 Procedures for granting or denying exemptions

(a) A member granted a conditional exemption shall be granted a final exemption from assessments for reimbursements for losses accruing for the calendar year in which the conditional exemption was granted if the Board determines that the information filed by the member pursuant to N.J.A.C. 11:20-8 and this subchapter evidences the following:

1. By the end of calendar year 1993, the member has enrolled or insured at least 40 percent of the minimum number of non-group persons allocated to it by the Board;

2. By the end of calendar year 1994, the member has enrolled or insured at least 75 percent of the minimum number of non-group persons allocated to it by the Board; and

3. By the end of calendar year 1995 and thereafter in each calendar year, the member has enrolled or insured 100 percent of the minimum number of non-group persons allocated to it by the Board.

(b) Members receiving final exemptions from the Board shall not be liable for any portion of any assessments for reimbursements for losses for the calendar year for which the final exemption is granted. The Board shall determine, in writing, whether the member is granted a final exemption on or before the date that the Board issues bills for assessments for reimbursements for losses for the preceding calendar year.

1. A member granted a conditional exemption that enrolls or insures fewer than the minimum number of non-group persons allocated to it by the Board shall be liable for a pro rata exemption from assessments for reimbursements for losses based upon the percentage of the minimum number of non-group persons actually enrolled or insured by the member, subject to a demonstration by the member in writing to the Board that the member has made a good faith effort to enroll or insure the minimum number of non-group persons allocated to it by the Board.

2. If the Board finds that the member has not made a good faith effort to enroll or insure its minimum number of non-group persons, the Board shall not grant a pro rata exemption to the member. The Board shall notify the member in writing as to its reasons for not granting the member a pro rata exemption on or before the date that the Board issues bills for assessments for reimbursements for losses for the preceding calendar year.

(c) Members denied a pro rata exemption from assessments for reimbursements for losses may, within 20 days of the date of the Board's ruling, request 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. A request for a hearing shall include a detailed explanation of the reasons why the Board's action should be reconsidered.

(d) A member requesting a hearing by the Board shall remain liable for the full amount of any assessments for reimbursements for losses issued to it by the Board, until and unless the Board makes a finding that the member is liable for a pro rata assessment only, including any interest that may accrue.

(e) Members granted final exemptions or pro rata exemptions shall not be liable for any amount of reimbursements for losses which remain unreimbursed in accordance with N.J.S.A. 17B:27A-12e.

APPENDIX
EXHIBIT A

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for a BASIC health benefits plan.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
BASIC HEALTH BENEFITS PLAN
(New Jersey BASIC Health Benefits Plan)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey BASIC Health Benefits Plan.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page 21.

All nouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

[**ALLOWANCE.** What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.]

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured. Eligible Medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or Your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or Spouse is not a Child for purposes of eligibility for benefits under this Policy.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 20;
  (3) unmarried Child from age 20 until the child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supportive;
  (2) the Child's condition started before the child reached this Policy's age limit;
  (3) the Child became insured before the child reached this Policy's age limit, and stayed continuously insured until he reached such limit; and
  (4) the Child depends on You for most of the child's support and maintenance.

  In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the child's support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Doctor practices; and
(b) provides medical services which are within the scope of the Doctor's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equipment must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which mainly provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A facility which mainly provides Inpatient care for terminally Ill or Accidentally Injured people who are terminally injured. We will

recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital. A specialty facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Medical Care Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments and Coinsurance are also Non-covered Expenses.

[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits

Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY RESIDENCE. The location where You reside for a majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.

The Board may decide a standard for what is Reasonable and Customary under this Policy.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

(b) The correction of fractures and dislocations;

(c) Reasonable and Customary pre-operative and post-operative care; or

(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or

(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury, Mental or Nervous Condition or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherpay—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment of the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Benefits Plan that provides the same or similar coverage and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED LIFETIME MAXIMUM.

FACILITY BENEFIT—30 days Inpatient Hospital care.

FACILITY COINSURANCE—20% up to a maximum of $5000/ Covered Person (then 100%, up to 30 days).

DOCTORS' SERVICES—50% Inpatient and Outpatient (incl. Surgery, anesthesia, radiology and obstetrics).

CASH DEDUCTIBLES:

INPATIENT (separate)—$1000/admission/Covered Person; max. of two Inpatient Deductibles/Covered Person.

OTHER COVERED CHARGES—$250/Covered Person, $500/ family.

EMERGENCY ROOM—We will only pay $50/visit/Covered Person.

PRIMARY CARE SERVICES—$100/Covered Person, $300/family. Primary Care Services are not subject to Deductibles and Coinsurance.

NOTE: OUR PAYMENTS WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage	[$]
For Parent and Child(ren) Coverage	[$]
For Family Coverage	[$]
For Policyholder and Spouse	[$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately before the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's Schedule of Premium Rates. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: For Inpatient Hospital services and supplies You must pay one Inpatient Deductible per Period of Confinement before We pay any benefits. For other Covered Charges, each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the schedule. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable

Coinsurance and Copayments, for the rest of that Benefit Period. However, a Covered Person must satisfy two Inpatient Deductibles per Benefit Period. And all charges must be incurred while You are insured by this Policy. What We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family aggregate deductible cap on care equal to two Deductibles for each Benefit Period. This does not apply to the Inpatient Hospital Deductible. Once the family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Inpatient Hospital Coinsurance amounts You must pay. The Coinsurance cap cannot be met with Non-Covered Expenses, Copayments and Deductibles.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period for the Inpatient Hospital benefit. But We do not provide benefits for more than 30 Inpatient Hospital days per Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD. HOWEVER, A COVERED PERSON WILL RECEIVE CREDIT FOR ANY INPATIENT DEDUCTIBLE SATISFIED DURING A PERIOD OF CONFINEMENT PRECEDING A NEW BENEFIT PERIOD.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan which provides the same or similar coverage. We do this so that no one gets more in benefits than the Covered Person incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductible, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE HOSPITAL ADMISSION REVIEW PROGRAM IN THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Doctor other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless he is a Dependent.

Blood: We cover Inpatient blood transfusions only.

Daily Room and Board Limits:
(During a Period of Hospital Confinement)

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For Special Care Units, Ee cover charges up to the Hospital's actual daily room and board charge.

Doctor Charges for Nonsurgical Care and Treatment: We only cover Doctor charges for nonsurgical care and treatment of an Illness or Accidental Injury under Primary Care Services. See the "Schedule of Benefits" and "Primary Care Services" sections of this Policy.

Doctor Charges for Surgery: We cover Doctor charges for Surgery. But, We do not cover charges for cosmetic Surgery.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan on the basis of two Home Health Care days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as:

(a) Skilled Nursing Care furnished by or under the supervision of a registered Nurse;
(b) Therapy Services;
(c) Medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.

But, payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Doctor must certify that home health care is needed in place of Inpatient care in a recognized facility;
(b) the services and supplies must be: (a) ordered by Your Doctor; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis;
(c) the home health care plan must be set up in writing by your Doctor within 14 days after home health care starts;
(d) each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Doctor has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Doctor.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy on the basis of two Inpatient Hospice days in exchange for each Inpatient Hospital day relinquished. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Doctor;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;

(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan;
(e) services supplied to family members, other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery. However, We do not cover specialist consultations in a Hospital.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Test Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Second Opinion Charges: We cover Doctor charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second (or third) opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Center: Subject to Our advance written approval, when Skilled Nursing Care can take the place of Inpatient care, We cover such care furnished to You in a Skilled Nursing Center on the basis of two Skilled Nursing Center days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as: any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care facility, provided such service is administered in a Skilled Nursing Center.

Therapy Services: We cover Inpatient and Outpatient Chemotherapy and Radiation Therapy. We cover other Therapy Services only on an Inpatient basis. But we do not cover Dialysis Treatment.

X-Rays and Laboratory Tests: We cover Inpatient and Outpatient x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for Your Pre-Existing Condition to the extent that the condition was satisfied under another carrier's plan which insured You right before Your coverage under this Policy started, In other words, where there was no gap in coverage.

Primary Care Services: We will cover up to $100 per Covered Person per Benefit Period, up to a maximum of $300 per family per Benefit Period, for routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to Deductibles or Coinsurance.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request Our Care Preapproval

If your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplant
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
Tympanostomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care
CAT Scan
Magnetic Resonance Imaging

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
Cystoscopy

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Hospice Care
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review.

NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL MAKE NO PAYMENT.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 2—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 3 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 3 below.

If the Second opinion does not confirm the need for the procedure, We may require you to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 3 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 3—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 2 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, WE WILL NOT MAKE ANY PAYMENT FOR FACILITY CHARGES.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

IX. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Alcoholism.

Ambulance—air, water, ground and rail.

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Dialysis treatment.

Durable Medical Equipment.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations; eyeglasses, contact lenses, and all fittings, except as specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids, hearing examinations or fitting of hearing aids.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury which occurred on the job or which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately by a Doctor for Surgery performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Mental or Nervous Conditions.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Outpatient Prescription Drugs.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Accidental Injury.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
- —for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
- —provided by or in any locale outside the United States, except in the case of a medical emergency;
- —provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
- —provided by a social worker, except as otherwise stated in this Policy;
- —received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- —rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
- —which are specifically limited or excluded elsewhere in this Policy;
- —which are not Medically Necessary and Appropriate; or
- —which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to Your treatment (e.g. employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Substance Abuse.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

Transplants, and non-human organ transplants.

TMJ Syndrome: dental treatment of TMJ Syndrome, including, but not limited to, crowns, bridgework and intraoral prosthetic devices.

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Accidental Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent of the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may[, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will let You know in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date of the original declination.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.

XII. GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:
(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will avoid the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:
(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:
(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) cancellation or amendment by the Board of this basic health benefits plan.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date the Child attains the Policy's age limit, or marries, or when a step-child is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND NON-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the Schedule of Benefits, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by a Non-Network Provider may be different than our Network Provider Allowance; also, a Non-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible facility or Doctor, We will Determine to pay either You or the facility or Doctor.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

EXHIBIT B

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan B.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN B
(New Jersey Individual Health Benefits Plan B)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan B.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this Policy. Information about Your benefits begins on page 00.

All pronouns in the singular used in this Policy will be deemed to include plural also, unless the context clearly indicates the contrary.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

[**ALLOWANCE.** What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.]

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured. Eligible Medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws; or
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or your legally adopted child, and Your Stepchild if the child depends on You for most of the child's support and maintenance, Your step-child. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or Spouse is not a Child for purposes of eligibility for benefits under this Policy.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 20;
  (3) unmarried Child from age 20 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supportive;
  (2) the Child's condition started before he reached this Policy's age limit;
  (3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until he reached such limit; and
  (4) the Child depends on You for most of the Child's support and maintenance.

  In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the Child's support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Doctor practices; and
(b) provides medical services which are within the scope of the Doctor's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:
1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which mainly provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A facility which mainly provides Inpatient care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital.

A specialty facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Medical Care Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:
(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any

underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments and Coinsurance are also Non-covered Expenses.

[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and

(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and

(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY RESIDENCE. The location where You reside for the majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.

The Board may decide a standard for what is Reasonable and Customary under this Policy.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:
(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury, Mental or Nervous Condition or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment for the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:
(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.
(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO PER LIFETIME MAXIMUM OF $1,000,000.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—40%.

OTHER COVERED CHARGES—40% up to $3,000/Covered Person, $6,000/family.

COINSURANCE CAP—After $3,000/Covered Person, $6,000/family, We pay 100%.

CASH DEDUCTIBLES:

INPATIENT (separate)—$200/day for the first 5 days of Inpatient Hospital care up to $1,000/admission/Covered Person for two admissions/Benefit Period.

OTHER COVERED CHARGES—[$250] [$500] [$1,000]/Covered Person, [$500] [$1,000] [$2,000]/family. This Deductible is in addition to the Inpatient Deductible.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—365 days, if preapproved.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

HOSPICE CARE—180 days/Covered Person, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient. Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life.

SPINAL MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Service.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage	[$]
For Parent and Child(ren) Coverage	[$]
For Family Coverage	[$]
For Policyholder and Spouse	[$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately before the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's Schedule of Premium Rates. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: For Inpatient Hospital services You must pay an Inpatient Deductible, up to two per Benefit Period, per Period of Confinement before We pay any benefits. For other Covered Charges, each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the schedule. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. This does not apply to the Inpatient Hospital Deductible. Once family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Inpatient Hospital Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses, Copayments and Deductibles.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period for the Inpatient Hospital benefit.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD. HOWEVER, A COVERED PERSON WILL RECEIVE CREDIT FOR ANY INPATIENT HOSPITAL DEDUCTIBLE SATISFIED DURING A PERIOD OF CONFINEMENT PRECEDING A NEW BENEFIT PERIOD.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than the Covered Person incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

Covered Charges for services and supplies rendered Inpatient are subject to the Inpatient Hospital Deductible.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Doctor. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center.

But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Doctor other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products, and blood transfusions, except as limited in the section of this Policy called "Exclusions."

Daily Room and Board Limits:

During a Period of Hospital Confinement

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

Doctor Charges for Nonsurgical Care and Treatment: We cover Doctor charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

Doctor Charges for Surgery: We cover Doctor charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.

But, payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Doctor must certify that home health care is needed in place of Inpatient care in a recognized facility.
(b) The services and supplies must be: (a) ordered by Your Doctor; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by your Doctor within 14 days after home health care starts. And it must be reviewed by Your Doctor at least once every 60 days.
(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program, up to 180 days per Benefit Period.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Doctor has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Doctor.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Doctor;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan;
(e) services supplied to family members, other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Preadmission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Test Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including, but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs.

Second Opinion Charges: We cover Doctor charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Center: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including: any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care facility, provided such service is administered in a Skilled Nursing Center.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Doctor, psychologist or social worker.

You must pay Coinsurance of 40% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for Your Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which insured You right before Your coverage under this Policy started, i.e., no intervening lapse in coverage.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for most Therapy Services.

We cover Radiation Therapy and Chemotherapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Transplants: Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas. Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request Our Care Preapproval

If your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
Tympanostomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care
CAT Scan
Magnetic Resonance Imaging

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
Cystoscopy

OTHER SERVICES AND SUPPLIES

Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment

Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review.

NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND THOSE CHARGES WILL BE NON-COVERED EXPENSES.

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL MAKE NO PAYMENT.**

Failure to notify Us of the procedures, services and supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 2—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 3 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 3 below.

If the second opinion does not confirm the need for the procedure, We may require you to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 3 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 3—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 2 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, WE WILL NOT MAKE ANY PAYMENT FOR FACILITY CHARGES.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

IX. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations; eyeglasses, contact lenses, and all fittings, except as specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids, hearing examinations or fitting of hearing aids.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury which occurred on the job or which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately by a Doctor for Surgery performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Accidental Injury.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

—eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain this coverage or payment for services;
—for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
—for which You would not have been charged if You did not have health care coverage;
—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—in an amount greater than a Reasonable and Customary charge;
—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
—provided by or in any locale outside the United States, except in the case of a medical emergency;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—provided by a social worker, except as otherwise stated in this Policy;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex harmones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including, but not limited to, crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Accidental Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive due written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may[, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will let You know in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date of the original declination.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.

XII. GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:
(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will avoid the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:
(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:
(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan that provides the same or similar coverage;
(e) cancellation or amendment by the Board of this individual health benefits plan.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date the Child attains the Policy's age limit, or marries, or when a step-child is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it

is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND NON-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the Schedule of Benefits, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by a Non-Network Provider may be different than our Network Provider Allowance; also, a Non-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible facility or Doctor, We will Determine to pay either You or the facility or Doctor.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

EXHIBIT C

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan C.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN C
(New Jersey Individual Health Benefits Plan C)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan C.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page 00.

All personal pronouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of Illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

[**ALLOWANCE.** What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charges. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.]

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured. Eligible medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or Your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or Spouse is not a Child for purposes of eligibility for benefits under this Policy.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 20;
  (3) unmarried Child from age 20 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supportive;
  (2) the Child's condition started before the Child reached this Policy's age limit;
  (3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until he reached such limit; and
  (4) the Child depends on You for most of the Child's support and maintenance.

  In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the Child's support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Doctor practices; and
(b) provides medical services which are within the scope of the Doctor's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or

(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or

(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which mainly provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A facility which mainly provides Inpatient care for terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare; or

(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited as a hospital by the Joint Commission, or

(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital.

A specialty facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Medical Care Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;

(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;

(c) in accordance with accepted medical standards in the community at the time;

(d) not for Your convenience; and

(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments and Coinsurance are also Non-covered Expenses.

[**NON-NETWORK PROVIDER.** A Provider which is not a Network Provider.]

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and

(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and

(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY RESIDENCE. The location where You reside for a majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.

The Board may decide a standard for what is Reasonable and Customary under this Policy.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

(b) The correction of fractures and dislocations;

(c) Reasonable and Customary pre-operative and post-operative care; or

(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury, Mental or Nervous Condition or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherpay—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment of the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.
(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—30%.

OTHER COVERED CHARGES—30% up to $2,500/Covered Person, $5,000/family.

COINSURANCE CAP—After $2,500/Covered Person, $5,000/family, We pay 100%.

CASH DEDUCTIBLE—[$250] [$500] [$1,000]/Covered Person, [$500] [$1,000] [$2,000]/family.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—180 days/Covered Person, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient. Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

SPINAL MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Service.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Policyholder and Spouse ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately before the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's Schedule of Premium Rates. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the schedule. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses, Copayments and Deductibles.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than the Covered Person incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Doctor. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Doctor other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products, and blood transfusions, except as limited in the section of the Policy called "Exclusions."

Daily Room and Board Limits

During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

Doctor Charges for Nonsurgical Care and Treatment: We cover Doctor charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

Doctor Charges for Surgery: We cover Doctor charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Doctor must certify that home health care is needed in place of Inpatient care in a recognized facility.
(b) The services and supplies must be: (a) ordered by Your Doctor; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by your Doctor within 14 days after home health care starts. And it must be reviewed by Your Doctor at least once every 60 days.
(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program, up to 180 days per Benefit Period.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Doctor has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs if You are terminally Ill. It must be set up in writing and reviewed periodically by Your Doctor.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Doctor;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan;
(e) services supplied to family members, other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Preadmission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including, but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs.

Second Opinion Charges: We cover Doctor charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including: any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care facility, provided such service is administered in a Skilled Nursing Center.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Doctor, psychologist or social worker.

You must pay Coinsurance of 30% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for Your Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which insured You right before Your coverage under this Policy started, i.e., no intervening lapse in coverage.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for most Therapy Services.

We cover Radiation Therapy and Chemotherapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Transplants: Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas. Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request Our Care Preapproval

If your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
Tympanostomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care
CAT Scan
Magnetic Resonance Imaging

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
Cystoscopy

OTHER SERVICES AND SUPPLIES

Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review.

NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL MAKE NO PAYMENT.**

Failure to notify Us of the procedures, services and supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 2—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 3 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 3 below.

If the Second opinion does not confirm the need for the procedure, We may require you to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 3 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 3—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 2 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, WE WILL NOT MAKE ANY PAYMENT FOR FACILITY CHARGES.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

IX. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations; eyeglasses, contact lenses, and all fittings, except as specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids, hearing examinations or fitting of hearing aids.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury which occurred on the job or which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately by a Doctor for Surgery performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Accidental Injury.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
- —for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related

Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
—provided by or in any locale outside the United States, except in the case of a Medical Emergency;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—provided by a social worker, except as otherwise stated in this Policy;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex harmones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including, but not limited to, crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish You with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Accidental Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may[, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will let You know in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:
(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date of the original declination.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:
(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have

been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.

XII. GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will avoid the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) cancellation or amendment by the Board of this individual health benefit plan.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date the Child attains the Policy's age limit, or marries, or when a stepchild is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND NON-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the Schedule of Benefits, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by a Non-Network Provider may be different than our Network Provider Allowance; also, a Non-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible facility or Doctor, We will Determine to pay either You or the facility or Doctor.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

EXHIBIT D

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan D.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN D
(New Jersey Individual Health Benefits Plan D)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan D.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page —.

All personal pronouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

[**ALLOWANCE.** What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charge. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.]

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured. Eligible medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that you submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or Spouse is not a Child for purposes of eligibility for benefits under this Policy.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 20;
  (3) unmarried Child from age 20 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supportive;
  (2) the Child's condition started before the Child reached this Policy's age limit;
  (3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until he reached such limit; and
  (4) the Child depends on You for most of the Child's support and maintenance.

  In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the Child's support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Doctor practices; and
(b) provides medical services which are within the scope of the Doctor's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective

and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equipment must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which mainly provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A facility which mainly provides Inpatient care for terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital.

A specialty facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Medical Care Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK PROVIDER. A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments and Coinsurance are also Non-covered Expenses.

[NON-NETWORK PROVIDER. A Provider which is not a Network Provider.]

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and

(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY RESIDENCE. The location where You reside for a majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.

The Board may decide a standard for what is Reasonable and Customary under this Policy.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, destrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

(b) The correction of fractures and dislocations;

(c) Reasonable and Customary pre-operative and post-operative care; or

(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or

(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury, Mental or Nervous Condition or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment of the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—25%.

OTHER COVERED CHARGES—20% up to $2,000/Covered Person, $4,000/family.

CASH DEDUCTIBLE—[$250] [$500] [$1,000]/Covered Person, [$500] [$1,000] [$2,000]/family.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—180 days/Covered Person, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient. Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first years of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

SPINAL MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Service.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage ..... [$]

For Parent and Child(ren) Coverage ..... [$]

For Family Coverage ..... [$]
For Policyholder and Spouse ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately before the date the Covered Person's coverage has ended.
(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's Schedule of Premium Rates. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;
(b) any date that the extent or nature of the risk under the Policy is changed:
  (1) by amendment of the Policy; or
  (2) by reason of any provision of law or any government program or regulation;
(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the schedule. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses, Copayments and Deductibles.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than the Covered Person incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE HOSPITAL ADMISSION REVIEW PROGRAM IN THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Doctor. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Doctor other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products, and blood transfusions, except as limited in the section of this Policy called "Exclusions."

Daily Room and Board Limits:
During a Period of Hospital Confinement

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

Doctor Charges for Nonsurgical Care and Treatment: We cover Doctor charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

Doctor Charges for Surgery: We cover Doctor charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Doctor must certify that home health care is needed in place of Inpatient care in a recognized facility;
(b) the services and supplies must be: (a) ordered by Your Doctor; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis;
(c) the home health care plan must be set up in writing by Your Doctor within 14 days after home health care starts. And it must be reviewed by Your Doctor at least once every 60 days;
(d) each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program, up to 180 days per benefit period.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Doctor has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Doctor.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Doctor;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan;
(e) services supplied to family members, other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Preadmission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs.

Second Opinion Charges: We cover Doctor charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including: any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care facility, provided such service is administered in a Skilled Nursing Center.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Doctor, psychologist or social worker.

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for Your Pre-Existing Condition to the extent that the condition was satisfied under another carrier's plan which insured You right before Your coverage under this Policy started, i.e., no intervening lapse in coverage.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to Deductibles or Coinsurance.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for most Therapy Services.

We cover Radiation Therapy and Chemotherapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Transplants: Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas. Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request Our Care Preapproval

If your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
Tympanostomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care
CAT Scan
Magnetic Resonance Imaging

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
Cystoscopy

OTHER SERVICES AND SUPPLIES

Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review.

NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL MAKE NO PAYMENT.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 2—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 3 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 3 below.

If the Second opinion does not confirm the need for the procedure, We may require you to get a third opinion. If that happens, We will

arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 3 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 3—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 2 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, WE WILL NOT MAKE ANY PAYMENT FOR FACILITY CHARGES.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

IX. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations; eyeglasses, contact lenses, and all fittings, except as specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids, hearing examinations or fitting of hearing aids.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury which occurred on the job or which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately by a Doctor for Surgery performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Accidental Injury.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
- —for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
- —provided by or in any locale outside the United States, except in the case of a medical emergency;
- —provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
- —provided by a social worker, except as otherwise stated in this Policy;
- —received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- —rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
- —which are specifically limited or excluded elsewhere in this Policy;

—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Covered Person (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Substance Abuse.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Accidental Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the recognized Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will let You know in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date of the original declination.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Coveraged Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.

XII. GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;

(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will avoid the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].
(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].
(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.
(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 A.M. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, his eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) cancellation or amendment by the Board of this individual health benefits plan.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 A.M. on the date the Child attains the Policy's age limit, or marries, or when a stepchild is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND NON-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the Schedule of Benefits, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by a Non-Network Provider may be different than our Network Provider Allowance; also, a Non-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible facility or Doctor, We will Determine to pay either You or the facility or Doctor.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

EXHIBIT E

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan E.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
INDIVIDUAL HEALTH BENEFITS PLAN E
(New Jersey Individual Health Benefits Plan E)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid, or a Group Health Benefits Plan that provides the same or similar coverage. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this New Jersey Individual Health Benefits Plan E.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page 00.

All personal pronouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.

ADMISSION. See the definition for "Period of Confinement."

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of Illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

[**ALLOWANCE.** What We agree to pay a Provider. For this Policy, We will generally pay based on the standard measure of such Reasonable and Customary charges approved by the State of New Jersey Individual Health Coverage Program Board.

However, a Provider may agree with Us to accept a lesser charge for such services and supplies than the Reasonable and Customary Charges. If a Provider so agrees, then that lesser charge will be the basis for determining Your benefit and Our Allowance under the Policy.]

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT MONTH. The one-month period starting on the day Your coverage starts and each one-month period after that date.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured. Eligible medical expenses must be incurred during this period in order to be Covered Charges.

BIRTHING CENTER. A facility which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or Your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or Spouse is not a Child for purposes of eligibility for benefits under this Policy.

COINSURANCE. The percentage of a Covered Charge that must be paid by You. Coinsurance does not include Cash Deductibles, Copayments or Non-Covered Expenses.

COPAYMENT. A specified dollar amount which You must pay for certain Covered Charges.

COVERED CHARGE. Reasonable and Customary charges for the types of services and supplies described in the "Covered Charges" and "Covered Charges with Special Limitations" sections of this Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

A Covered Charge is incurred by You while You are insured by this Policy. Read the entire Policy to find out what We limit or exclude.

COVERED PERSON. An eligible person who is insured under this Policy.

CURRENT PROCEDURAL TERMINOLOGY (C.P.T.). The most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 20;
  (3) unmarried Child from age 20 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.
(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supportive;
  (2) the Child's condition started before the Child reached this Policy's age limit;
  (3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until he reached such limit; and
  (4) the Child depends on You for most of the Child's support and maintenance.

  In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of the Child's support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the Doctor practices; and
(b) provides medical services which are within the scope of the Doctor's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or Your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological

product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equipment must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which mainly provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A facility which mainly provides Inpatient care for terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital.

A specialty facility is also not a Hospital.

HOSPITAL ADMISSION REVIEW. The authorization of coverage for benefits under this Policy which You obtain from Us prior to an Inpatient Hospital admission. In the event of a Medical Emergency, You must notify Us within 48 hours of Your admission to a [Non-Network] Provider due to that Medical Emergency, or Your benefits will be reduced. See the section of this Policy called "Medical Care Utilization Review" for details.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:
(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK PROVIDER. A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments and Coinsurance are also Non-covered Expenses.

[NON-NETWORK PROVIDER. A Provider which is not a Network Provider.]

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
(a) is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
(b) provides medical services which are within the scope of the Nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:
(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Covered Person who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, x-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY RESIDENCE. The location where You reside for the majority of a Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.

The Board may decide a standard for what is Reasonable and Customary under this Policy.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

(b) The correction of fractures and dislocations;

(c) Reasonable and Customary pre-operative and post-operative care; or

(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or

(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury, Mental or Nervous Condition or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment of the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—25%.

OTHER COVERED CHARGES—10% up to $1,500/Covered Person, $3,000/family.

COINSURANCE CAP—After $1,500/Covered Person, $3,000/family, We pay 100%.

CASH DEDUCTIBLES—[$150] [$500] [$1,000]/Covered Person, [$300] [$1,000] [$2,000]/family.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient. Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductibles or Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

SPINAL MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Service.

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED OR ELIMINATED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage	[$]
For Parent and Child(ren) Coverage	[$]
For Family Coverage	[$]
For Policyholder and Spouse	[$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month

period immediately before the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's Schedule of Premium Rates. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the schedule. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses, Copayments and Deductibles.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Payment Limits: We limit what We pay for certain types of charges.

Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan which provides the same or similar coverage. We do this so that no one gets more in benefits than the Covered Person incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductible, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a Doctor. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible facility, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a Doctor other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products, and blood transfusions, except as limited in the section of this Policy called "Exclusions."

Daily Room and Board Limits:

During a Period of Hospital Confinement

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, 90% of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

Doctor Charges for Nonsurgical Care and Treatment: We cover Doctor charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

Doctor Charges for Surgery: We cover Doctor charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover

such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) Medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your Doctor must certify that home health care is needed in place of Inpatient care in a recognized facility;
(b) the services and supplies must be: (a) ordered by Your Doctor; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis;
(c) the home health care plan must be set up in writing by your Doctor within 14 days after home health care starts. And it must be reviewed by Your Doctor at least once every 60 days.
(d) each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program, up to 180 days per Benefit Period.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that your Doctor has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your Doctor.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

(a) needed for palliative and supportive care;
(b) ordered by Your Doctor;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:

(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan;
(e) services supplied to family members, other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery.

If you incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Pread-mission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post-admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs.

Second Opinion Charges: We cover Doctor charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including:

(a) any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, an office or any other licensed health care facility, provided such service is administered in a Skilled Nursing Center.

Treatment for Therapeutic Manipulation: We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Doctor, psychologist or social worker.

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for Your Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which insured You

right before Your coverage under this Policy started, i.e., no intervening lapse in coverage.

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for most Therapy Services.

We cover Radiation Therapy and Chemotherapy as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Transplants: Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas. Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY.)

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request Our Care Preapproval

If your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
Tympanostomy Tube

MEDICAL PROCEDURES

Lower Back Medical Care
CAT Scan
Magnetic Resonance Imaging

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
Cystoscopy

OTHER SERVICES AND SUPPLIES

Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review.

NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL MAKE NO PAYMENT.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP 2—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step 3 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step 3 below.

If the Second opinion does not confirm the need for the procedure, We may require you to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step 3 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP 3—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step 2 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, WE WILL NOT MAKE ANY PAYMENT FOR FACILITY CHARGES.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

IX. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Any charge to the extent it exceeds Our Allowance.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of claim forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eye examinations; eyeglasses, contact lenses, and all fittings, except as specified in this Policy; surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids, hearing examinations or fitting of hearing aids.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury which occurred on the job or which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately by a Doctor for Surgery performed on an Outpatient basis.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Pre-Existing Conditions, for the first 365 days of coverage in effect for You and Your Dependents.

Private-Duty Nursing, unless You have followed the section of this Policy called "Request Our Care Preapproval."

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine examinations or preventive care, including related x-rays and laboratory tests, except as otherwise stated in this Policy; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Accidental Injury.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
- —for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
- —provided by or in any locale outside the United States, except in the case of a medical emergency;
- —provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
- —provided by a social worker, except as otherwise stated in this Policy;
- —received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- —rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
- —which are specifically limited or excluded elsewhere in this Policy;
- —which are not Medically Necessary and Appropriate; or
- —which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Covered Person (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. CLAIMS PROCEDURES

Your right to make a claim for any benefits provided by this Policy is governed as follows:

You or Your Provider must send us written notice of a claim. This notice should include Your name and Policy number. If the claim is being made for one of Your covered Dependents, the Dependent's name should also be noted. A separate claim form is needed for each claim submitted.

Proof of Loss: We will furnish you with forms for filing a proof of loss within 15 days of receipt of notice of claim. But if We do not furnish the forms on time, We will accept a written description and adequate documentation of the Accidental Injury or Illness that is the basis of the claim as proof, including an itemized bill with patient identification, diagnosis, Provider name and license number, type of service and amount of charge for service. You or Your Provider must detail the nature and extent the claim being made. You or Your Provider must send Us written proof of loss within 90 days of the Covered Charge being incurred.

Late Notice of Proof: We will not void or reduce a claim if You cannot send Us notice and proof of loss immediately. But You or Your Provider must send Us notice and proof as soon as reasonably possible, but in no event later than one year following the date the proof of loss was otherwise required.

Payment of Benefits: We will pay all benefits to which You and Your Dependents are entitled as soon as We receive written proof of loss.

We pay all benefits to Your Provider or You, if You are living. If You are not living, We have the right to pay benefits to one or more of the following: (a) Your beneficiary; (b) Your estate; (c) Your spouse; (d) Your Parents; (e) Your Children; (f) Your brothers and sisters; and (g) any unpaid Provider of health care services.

When You file a proof of loss, We may [, subject to Your written instructions to the contrary,—optional for health service corporations] pay health care benefits to the Provider who provided the service for which benefits became payable. But We cannot tell You which Provider You must use.

Claims Appeal: If We decline Your claim in whole or in part, We will let You know in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date of the original declination.

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. COORDINATION OF BENEFITS

This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.

XII. GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will avoid the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may

change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].

(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].

(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.

(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 A.M. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;

(b) fraud or misrepresentation by You or Your Dependents;

(c) termination of Your eligibility or, with respect to Your Dependent, his eligibility;

(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;

(e) cancellation or amendment by the Board of this individual health benefits plan.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 A.M. on the date the Child attains the Policy's age limit, or marries, or when a stepchild is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

OFFSET

We reserve the right, before paying benefits to You, to use the amount of payment due to offset any unpaid Premiums or a claims payment previously made in error.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto. However, We may, in Our Discretion, pay a Provider directly for services rendered to You.

[NETWORK AND NON-NETWORK PROVIDER REIMBURSEMENT

Payment amounts, as specified in the Schedule of Benefits, apply to Covered Charges incurred for services rendered or supplies provided by an eligible Provider.

A Network Provider will generally accept Our Allowance plus any Deductible, Coinsurance and Copayment You are required to make as payment in full for services rendered or supplies provided.

Our Allowance for Covered Charges for treatment rendered by a Non-Network Provider may be different than our Network Provider Allowance; also, a Non-Network Provider may bill You for the difference between Our Allowance and the Provider's actual charge.

In no event will Our payment be more than the Provider's actual charge.]

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to Us.

RECORDS—INFORMATION TO BE FURNISHED

We will keep a record of Your benefits. It will contain key facts about Your coverage.

We will not have to perform any duty that depends on data before it is received from You in a form that satisfies Us. You may correct wrong data given to Us, if We have not been harmed by acting on it.

You must notify Us immediately of any event, including a change in eligibility, that may cause the termination of Your Coverage.

RELEASE OF RECORDS

By applying for benefits, You agree to allow all Providers to give Us needed information about the services and supplies they provide. We keep this information confidential. If a Provider requires special authorization for release of records, You agree to provide this authorization. Your failure to provide authorization or requested information will result in the declination of Your claim.

As Determined by Us, We may use appropriate non-employees, subsidiaries, or companies to conduct confidential medical record review for Our purposes.

[POLICYHOLDER/PROVIDER RELATIONSHIP

We are not Providers as defined in this Policy. We supply services in connection with conducting the business of insurance. This means We make Payment for Covered Charges incurred by persons eligible for benefits under this Policy.

We are not liable for any act or omission of any Provider nor any injury caused by a Provider's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

We are not responsible for a Provider's failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.]

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, Your Spouse may apply for Your Spouse's own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

DETERMINATION OF SERVICES

If the nature or extent of a given service must be determined, this Determination is entirely up to Us.

OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible facility or Doctor, We will Determine to pay either You or the facility or Doctor.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

EXHIBIT F

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the HMO health benefits plan.

Notice of Right to Examine Policy. Within 30 days after delivery of this Policy to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The Policy will be deemed void from the beginning.

[CARRIER]
HEALTH MAINTENANCE ORGANIZATION BENEFITS PLAN
(New Jersey HMO Health Benefits Plan)

Policy Term. The Policy takes effect on _____, the Policy Effective Date. The term of this Policy starts on Your Effective Date, may be renewed each year on the Anniversary Date, and will end no later than the day before the date You become eligible either for Medicare, Medicaid or a Group Health Benefits Plan. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to arrange or provide services under the terms and provisions of this Policy. But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom we cover under this HMO Health Benefits Plan.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand what services are provided. Information about the services provided under this Policy begins on page —.

ALCOHOLISM. Abuse of or addiction to alcohol.

ACCIDENTAL INJURY (OR ACCIDENTALLY INJURED). A sudden or unforeseen result of an external agent or trauma, independent of illness, which causes injury, including complications arising from that injury, to the body, and which is definite as to time and place.

AMBULANCE. A certified vehicle for transporting Ill or Accidentally Injured people that contains all life-saving equipment and staff as required by state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer insured.

BIRTHING CENTER. A facility which mainly provides care and treatment for people during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital or Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws; or
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A facility is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

CHILD. Your own issue or your legally adopted child and, if he depends on You for most of his support and maintenance, Your stepchild. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom you have legal custody or legal guardianship is considered a Child under this Policy. (We may require that you submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or the Policyholder's Spouse is not a Child for purposes of eligibility for services under this Policy.

[COINSURANCE. The percentage of a Covered Services or Supplies that must be paid by You. Coinsurance does not include Copayments or Non-Covered Expenses.]

COPAYMENT. A specified dollar amount which You must pay for certain Covered Services or Supplies.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this Policy. The services and supplies must be:

(a) furnished or ordered by a recognized health care Provider;
(b) Medically Necessary and Appropriate to diagnose or treat an Illness or Accidental Injury or provide Primary Care Services;
(c) accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Accidental Injury being treated; and
(d) furnished within the framework of generally accepted methods of medical management currently used in the United States.

Read the entire Policy to find out what We limit or exclude.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help You meet Your routine daily needs; or
(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age 20;
  (3) unmarried Child from age 20 until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask You to provide periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to support itself;
(2) the Child's condition started before the Child reached this Policy's age limit;
(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until the Child reached such limit; and
(4) the Child depends on You for most of the Child's support and maintenance.
In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of its support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
(a) radiology, ultrasound, and nuclear medicine;
(b) laboratory and pathology; and
(c) EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION/DETERMINATION BY US/DETERMINE. Our sole right to make a decision. Our decision will be applied in a reasonable and non-discriminatory manner.

DOCTOR. A medical practitioner We are required by law to recognize who:
(a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
(b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by this Policy.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
(a) designed and able to withstand repeated use;
(b) used primarily for a medical purpose;
(c) mainly and customarily used to serve a medical purpose;
(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to Your home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or your Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

GENERIC DRUG. An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

GROUP HEALTH BENEFITS PLAN. A policy, program or plan that provides medical benefits to a group of two or more individuals.

HOME HEALTH AGENCY. A Provider which mainly provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

HOSPICE. A facility which mainly provides Inpatient care for terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) approved for its stated purpose by Medicare; or
(b) it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited as a hospital by the Joint Commission, or
(b) approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A facility for the aged or for Substance Abusers is not a Hospital.

A specialty facility is also not a Hospital.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Accidental Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, burns, bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are

Medical Emergencies. We may, in our Discretion, consider other severe medical conditions requiring immediate attention to be Medical Emergencies.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending Doctor prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER. An eligible person who is covered under this Policy.

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current addition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement with Us to provide Covered Services or Supplies.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Copayments and Coinsurance are also Non-covered Expenses.

[NON- [NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not a [Network] [Participating] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
(b) provides medical services which are within the scope of the nurse's license or certificate and are covered by this Policy.

OUTPATIENT. You, if You are registered at a recognized health care facility and not an Inpatient; or services and supplies provided in such a setting.

PARTIAL HOSPITALIZATION. Day treatment services for Mental and Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A facility which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

POLICY. This agreement, any riders, amendments or endorsements, and the application signed by You and the premium schedule.

POLICYHOLDER. The Member who purchased this Policy.

POLICY TERM. The one-year period starting on the Effective Date and ending on the day before the Anniversary Date and, for each year this Policy is renewed, each one-year period thereafter.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, X-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a Doctor, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a Doctor in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition.

See the exclusions section of this Policy for details on how this Policy limits the benefits for Pre-Existing Conditions.

PREMIUM DUE DATE. The date on which a Premium is due under this Policy.

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a Doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for OB/GYN services only),] or pediatrics who supervises, coordinates and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIMARY RESIDENCE. The location where You reside for a majority of the Benefit Period with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intention to return, do not interrupt Your Primary Residence in New Jersey. A temporary absence may not exceed three months out of each Benefit Period.

PROVIDER. A recognized facility or practitioner of health care.

REFERRAL. Specific direction or instruction from Your Primary Care Physician that directs You to a facility or Provider for health care.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized facility for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Accidentally Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPECIALIST DOCTOR. A Doctor who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine or pediatrics.

SPOUSE. An individual legally married to the Policyholder under the laws of the State of New Jersey.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A facility that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
(b) The correction of fractures and dislocations;
(c) Reasonable and Customary pre-operative and post-operative care; or
(d) Any of the procedures designated by C.P.T. codes as surgery.

SURGICAL CENTER. A facility mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by Doctors and Nurses, under the supervision of a Doctor;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A facility is not a Surgical Center if it is part of a Hospital.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Accidental Injury or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment for the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

UNDERWRITING REQUIREMENTS. The rules which We Determine to be appropriate for making, maintaining and administering this Policy. Our rules do not require You to prove You or Your Dependents are in good health.

WE, US, OUR. [Carrier].

YOU, YOUR, AND YOURS. The Policyholder and any Dependents, as the context in which the term is used suggests.

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependent(s).
(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for a Group Health Benefits Plan, Medicare or Medicaid.
(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan.
(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply for a Policy to include Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, the Spouse will be covered from the date of the Spouse's eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Services or Supplies incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if you have Single Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and

submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of the Child's eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF SERVICES

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS POLICY ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER BENEFIT PERIOD, UNLESS OTHERWISE STATED.

FACILITY BENEFIT—Unlimited days.

COPAYMENTS:

HOSPITAL SERVICES:

INPATIENT—$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Benefit Period.

OUTPATIENT—$15 Copayment/visit.

DOCTOR SERVICES:

INPATIENT—None.

OUTPATIENT—$15 Copayment/visit; no Copayment if any other Copayment applies.

EMERGENCY ROOM—$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours).

ALCOHOLISM:

OUTPATIENT—$15 Copayment/visit for a maximum of 20 visits/Benefit Period.

INPATIENT—$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Benefit Period. Maximum of 30 days Inpatient care/Benefit Period. One Inpatient day may be exchanged for two Outpatient visits.

AMBULATORY SURGERY—$15 Copayment/visit.

BIRTHING CENTERS—$15 Copayment/visit.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CHARGES—Unlimited days, if preapproved.

MATERNITY (PRE-NATAL CARE)—$25 Copayment/initial visit.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE:

OUTPATIENT—$15 Copayment/visit for a maximum of 20 visits/Benefit Period.

INPATIENT—$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment $1,500/Benefit Period. Maximum of 30 days Inpatient care/Benefit Period. One Inpatient day may be exchanged for two Outpatient visits.

PODIATRIC—$15 Copayment/visit (excludes Routine Foot Care).

PRE-ADMISSION TESTING—$15 Copayment/visit.

PRESCRIPTION DRUG—50% Coinsurance [May be substituted by Carrier with $15 Copayment.]

PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES—$15 Copayment/visit.

PRIMARY CARE SERVICES—$15 Copayment/visit.

SECOND SURGICAL OPINION—$15 Copayment/visit.

SPECIALIST SERVICES—$15 Copayment/visit. You must have a Referral from Your Primary Care Physician.

SKILLED NURSING CARE—Unlimited days, if preapproved.

THERAPY SERVICES—$15 Copayment/visit.

X-RAY & LAB (OUTPATIENT)—$15 Copayment/visit.

NOTE: NO BENEFITS WILL BE PROVIDED IF YOU FAIL TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH YOUR PRIMARY CARE PHYSICIAN. READ THE GENERAL PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

The [monthly] premium rates, in U.S. dollars, for the coverage provided under this Policy are:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For Policyholder and Spouse ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premium Rate Changes."

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Member whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Member that was included in the Premiums paid for the two-month period immediately before the date the Member's coverage has ended.

(b) the amount of any claims paid or the value of any services provided to You or to a member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Premium Rates and Provisions section of the Policy. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

V. COVERED SERVICES

You are entitled to receive the benefits in the following sections when Medically Necessary, subject to the payment by you of applicable copayments as stated in the applicable Schedule of Benefits.

(a) **OUTPATIENT BENEFITS.** The following services are covered only at the Primary Care Physician's office selected by you, or elsewhere upon prior written referral by Your Primary Care Physician:

1. **Office visits** during office hours, and during non-office hours when Medically Necessary.
2. **Home visits** by your Primary Care Physician.
3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and

e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of your employment).

4. **Diagnostic Services.**
5. **Casts and dressings.**
6. **Ambulance Service** when certified in writing as Medically Necessary by your Primary Care Physician and approved in advance by Us.
7. **Infertility Services** except where specifically excluded in this Policy.
8. **Prosthetic Devices and Durable Medical Equipment** when ordered by your Primary Care Physician and arranged through Us. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements, repairs, wigs, or dental prosthetics or devices.
9. **Prescription Drugs.**

(b) **SPECIALIST DOCTOR BENEFITS.** The following Services are covered when rendered by a Participating Specialist Doctor at the Doctor's office or at a Participating Hospital outpatient department during office or business hours upon prior written referral by your Primary Care Physician. Services include but are not limited to the following:

1. Allergy (except serum injections which are covered when administered by your Primary Care Physician)
2. Anesthesia
3. Cardiology
4. Endocrinology
5. Gynecology and Obstetrics
6. Internal Medicine
7. Neurology
8. Oncology
9. Ophthalmology
10. Oral Surgery (bone fractures, removal of tumors and orthodontogenic cysts or other HMO-approved surgical procedures)
11. Orthopedics
12. Otolaryngology
13. Pathology
14. Pediatrics
15. Podiatry
16. Pulmonology
17. Radiology (except dental x-rays, unless related to Covered Services)
18. Surgery
19. Urology

(c) **INPATIENT HOSPITAL & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Doctor upon prior written referral from your Primary Care Physician, only at Participating Hospitals and Participating Providers (or at non-participating facilities upon prior written authorization by us); however, Participating Skilled Nursing Center benefits are limited to those which are Medically Necessary and which constitute Skilled Nursing Care:

1. Semi-private room and board accommodations
2. Private accommodations will be provided only when Medically Necessary as certified by your attending physician in concurrence with your Primary Care Physician and approved in advance by Us. If you occupy a private room without such certification you shall be directly liable to the Hospital or Skilled Nursing Center for the difference between payment by Us to the Hospital or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Participating Hospital or the Participating Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services
20. Private duty nursing only when Medically Necessary as certified by the Participating Specialist Physician or other attending physician in concurrence with your Primary Care Physician and approved in advance by Us.
21. The following transplants, when Medically Necessary: Cornea, Kidney, Lung, Liver, Heart, Pancreas, and Bone Marrow (for the treatment of Leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders (SCID and WISCOT Alldrich)).

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center upon prior written referral by your Primary Care Physician.

1. **Outpatient.** You are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by your Primary Care Physician for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for nonmedical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by your Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.
2. **Inpatient Hospital Care.** You are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

   Chemical Dependency Admissions. Repeated detoxification treatment for chronic substance abuse will not be covered unless in our sole discretion it is determined that You have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of substance abuse services.
3. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and only to the extent of the covered benefit as defined above.

(e) **ALCOHOLISM BENEFITS.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center upon prior written referral by your Primary Care Physician.

1. **Outpatient.** You are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical treatment and medical referral services by your Primary Care Physician for the abuse of or addiction to alcohol. Payment for nonmedical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. You are additionally eligible, upon referral by your Primary Care Physician, for up to sixty (60) more outpatient visits

by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** You are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, and referral services for substance abuse or addiction. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

   Detoxification Admissions. Repeated detoxification treatment for chronic alcoholism will not be covered unless in our sole discretion it is determined that You have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of alcoholism services.

3. Court-ordered alcohol admissions are not covered unless Medically Necessary and only to the extent of the covered benefit as defined above.

(f) **EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by your Primary Care Physician in the event of an Emergency as determined by us.

1. Your Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to your health, you shall call your Primary Care Physician prior to seeking emergency treatment.
2. We will cover the cost of emergency medical and hospital services performed within or outside our service area without a prior written referral only if:
   a. Our review determines that your symptoms were severe and delay of treatment would have been detrimental to your health, the symptoms occurred suddenly, and you sought immediate medical attention. Conditions which require immediate treatment include, but are not limited to the following:
      1. uncontrolled or excessive bleeding
      2. acute pain or conditions requiring immediate attention, such as suspected heart attack, severe shortness of breath or appendicitis
      3. serious burns
      4. poisoning
      5. convulsions
      6. unconsciousness

      A near-term delivery is not a Medical Emergency.
   b. The service rendered is provided as a benefit under this Policy and is not a service which is normally treated on a non-emergency basis; and
   c. We and your Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. You shall be responsible for payment for services received unless We determine that your failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event you are hospitalized in a non-participating facility, coverage will only be provided until You are medically able to travel or to be transported to a Participating facility. If You elect to continue treatment with Non-participating providers, We shall have no responsibility for payment beyond the date You are determined to be medically able to be transported.

   In the event that transportation is Medically Necessary, We will cover the reasonable cost as determined by us. Reimbursement may be subject to payment by you of all copayments which would have been required had similar benefits been provided during office hours and upon prior written referral to Participating Provider.
4. Coverage for emergency services includes only such treatment necessary to treat the emergency. Any elective procedures performed after You have been admitted to a facility as the result of an emergency shall require prior written referral or You shall be responsible for payment.
5. The copayment for an emergency room visit will not apply in the event that You were referred for such visit by your Primary Care Physician for services that could have been rendered in the Primary Care Physician's office or if You are admitted as an inpatient to the hospital as a result of the emergency.

(h) **THERAPY SERVICES.** The following Services are covered when rendered by a Participating Provider upon prior written referral by your Primary Care Physician.

1. Speech therapy, Physical therapy, occupational therapy and cognitive therapies are covered for non-chronic conditions and acute illnesses and injuries upon referral to a Participating Provider by your Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of illness or injury, beginning with the first day of treatment, provided that your Primary Care Physician certifies in writing that the treatment will result in a significant improvement of your condition within this time period and treatment is approved in writing by Us.
2. Chelation therapy, chemotherapy treatment, dialysis treatment, infusion therapy and radiation therapy.

(i) **HOME HEALTH BENEFITS.** The following Services are covered when rendered by a Participating Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by us upon the prior referral of your Primary Care Physician.

1. Skilled nursing services, provided by or under the supervision of a registered professional nurse.
2. Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to you is skilled in nature.
3. Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of your medical condition.
4. Therapy Services as set forth above.
5. Hospice Care if You are terminally ill with life expectancy of six months or less. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

VI. EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY.

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Any service provided without prior written Referral by the Member's Primary Care Physician except as specified in this Policy.

Any therapy not included in Our definition of Therapy Services.

Artificial and surgical drugs and procedures designed to enhance fertility, including, but not limited to, in-vitro fertilization, in-vivo fertilization or gamete-intra-fallopian-transfer (GIFT), and surrogate motherhood.

Blood or blood plasma which is replaced by You.

Broken appointments.

Christian Science.

Completion of forms.

Conditions related to behavior problems or learning disabilities.

Cosmetic Surgery, unless it is required as a result of an Accidental Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic Surgery; drugs prescribed for cosmetic purposes.

Custodial Care or domiciliary care.

Dental care or treatment, including appliances.

Education or training while You are confined in an institution that is primarily an institution for learning or training.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, including bony impacted teeth.

Eyeglasses, contact lenses, and all fittings: surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy.

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible facility.

Fluoroscopy or x-ray examinations without film.

Hearing aids, hearing examinations or fitting of hearing aids.

Herbal medicine.

High-dose chemotherapy, except as otherwise stated in this Policy.

Hypnotism.

Illness or Accidental Injury which occurred on the job or which is covered or could have been covered for services provided under workers' compensation, employer's liability, occupational disease or similar law.

Marriage, career or financial counseling, sex therapy or family therapy.

Membership costs for health clubs, weight loss clinics and similar programs.

Methadone maintenance.

Non-Prescription Drugs or supplies, except insulin needles and syringes.

Nutritional counseling and related services.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for Your Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which insured You right before the Your coverage under this Policy started, i.e., no intervening lapse in coverage.

Private-Duty Nursing, except as provided for under Home Health Care.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine Foot Care.

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
- —for which a charge is not usually made, such as a Doctor treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —needed because You committed or tried to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law;
- —provided by or in any locale outside the United States, except in the case of a medical emergency;
- —provided by a licensed pastoral counselor in the course of his normal duties as a pastor or minister;
- —provided by a social worker, except as otherwise stated in this Policy;
- —received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- —rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;
- —which are specifically limited or excluded elsewhere in this Policy;
- —which are not Medically Necessary and Appropriate;
- —which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Member (e.g., employment physicals, reports prepared in connection with litigation).

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Therapeutic Manipulations.

Transplants, unless otherwise specifically covered, and non-human organ transplants.

TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

VII. GRIEVANCE PROCEDURE

[**Grievance Procedure:** Variable by Carrier as approved by the State of New Jersey.]

VIII. COORDINATION OF BENEFITS

SERVICES AVAILABLE UNDER OTHER POLICIES

If Covered Services are provided under this Policy and these same Covered Services or expenses are covered under Other Valid Coverage, Our liability will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our liability on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Services) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Services) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the reasonable cash value of the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on an individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

IX. GENERAL PROVISIONS

AMENDMENT

The Policy may be amended, at any time, without Your consent or of anyone else with a beneficial interest in it. The Policyholder may change the type of coverage under this Policy at any time by notifying Us in writing.

We may make amendments to the Policy upon 30 days' notice to the Policyholder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Policy will be made without the approval of the Board.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of the Policy, to extend the time in which a Premium may be paid, to make or change a Policy, or to bind Us by a promise or representation or by information given or received.

No change in the Policy is valid unless the change is shown in one of the following ways:

(a) it is shown in an endorsement on it signed by an officer of [Carrier].

(b) if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Policy, as provided in the section of this Policy called "Conformity With Law," it is shown in an amendment to it that is signed by an officer of [Carrier].

(c) if a change is required by [Carrier], it is accepted by the Policyholder, as evidenced by payment of a Premium on or after the effective date of such change.

(d) if a written request for a change is made by the Policyholder, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

ASSIGNMENT

No assignment or transfer by You of any of Your interest under this Policy is valid unless We consent thereto.

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate your age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

CONFIDENTIALITY

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Policy or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us may not be disclosed without the Member's written consent.

CONFORMITY WITH LAW

If the provisions of the Policy do not conform to the requirements of any state or federal law that applies to the Policy, the Policy is automatically changed to conform with [Carrier's] interpretation of the requirements of that law, as approved by the Board.

CONTINUATION OF COVERAGE

If You die while this Policy is in force for You, Your Spouse and Dependents, Your Spouse and Dependents may continue coverage under this Policy for 180 days from Your date of death, provided that Your Spouse and Dependents elect to so continue within 31 days of Your date of death and subject to: (a) payment of the Premium when due; and (b) the Policy provisions for termination of Spouse and Dependents' coverage for reasons other than Your death.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Policy.

CONVERSION PRIVILEGE

If Your Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Policy ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Policy will apply under the new coverage to the extent it remains unsatisfied.

GOVERNING LAW

This entire Policy is governed by the laws of the State of New Jersey.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Policy is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Policy, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Policyholder, coverage may be terminated for the Policyholder as well as any of the Policyholder's Dependents who are Members. To be eligible for services or benefits under this Policy, the holder of the card must be a Member on whose behalf all applicable premium charges under this Policy have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Policy shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by us, and all rights of such Member and his or her Dependents, if any, pursuant to this Policy shall be terminated immediately, subject to the Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under this Policy, or similar causes, the rendition of medical or hospital benefits or other services provided under this Policy is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by You shall be used in contesting the validity of Your insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No Participating Provider or other provider, institution, facility or agency is our agent or employee. Neither HMO nor any employee of HMO is an agent or employee of any Participating Provider or other provider, institution, facility or agency.
2. Neither the Policyholder nor any Member is our agent, representative or employee, or an agent or representative of any Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Policy.
3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.
4. No Policyholder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by a duly authorized officer of HMO.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the policy until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

LIMITATION ON SERVICES

Except in cases of Medical Emergency, services are available only from Participating Providers. HMO shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by us.

MEDICAL NECESSITY

Members will receive designated benefits under the Policy only when Medically Necessary. We may determine whether any benefit provided under the Policy was Medically Necessary, and We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity are subject to review by the Quality Assessment Committee of HMO or its physician designee. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Policy that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under this Policy.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Policy may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

POLICY INTERPRETATION

We shall administer Policy in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

PRIMARY RESIDENCE REQUIREMENT

In order to obtain and continue health care coverage with Us, Your Primary Residence must be in New Jersey within our authorized Service Area. We reserve the right to require proof of Your Primary Residence.

We will cancel this Policy if You move Your Primary Residence outside of the State. We will give You at least 30 days' written notice of the cancellation.

REFERRAL FORMS

You can be referred for Specialist Services by Your Primary Care Physician.

You will be responsible for the cost of all services provided by anyone other than Your Primary Care Physician (including but not limited to Specialist Services) if You have not been referred by Your Primary Care Physician.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor HMO, or any Participating Provider will have further responsibility to provide any of the benefits available under this Policy for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure. The foregoing is not applicable if such refusal is according to a properly executed Advance Directive for medical treatment.

REPORTS AND RECORDS

HMO is entitled to receive from any provider of services to Member such information HMO deems is necessary to administer this Policy subject to all applicable confidentiality requirements as defined in this Policy. By accepting coverage under this Policy, Policyholder, for himself or herself, and for all Dependents covered hereunder, authorizes each and every provider who renders services to Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to Us upon request and to permit copying of Member's records by us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When You first obtain this coverage, You and each of Your Dependents must select a Primary Care Physician [or Health Center].

You select a Primary Care Physician from our Doctors Directory; this choice is solely Yours. However, We cannot guarantee the availability of a particular Doctor. If the Primary Care Physician initially selected cannot accept additional patients, You will be notified and given an opportunity to make another Primary Care Physician selection.

SERVICES FOR AUTOMOBILE RELATED INJURIES

When You are the named insured under a motor vehicle insurance Policy, You have two options under the terms of Your motor vehicle insurance Policy. The option You select will also determine coverage of any family member covered under that Policy who is not a separate named insured under another motor vehicle policy.

(a) You may choose to have primary coverage for such services covered under Your motor vehicle insurance Policy (the Personal Injury Protection or compulsory Medical Payment provisions of a New Jersey motor vehicle insurance Policy or under similar provisions of a motor vehicle Policy required by any other federal or state no-fault motor vehicle insurance law).

If You choose this option, We will provide secondary coverage in accordance with regulations issued by the Department of Insurance.

(b) You may choose to have primary coverage for such services provided by this Policy.

If You choose this option, We will provide benefits for any Covered Charges incurred for the diagnosis or treatment of an Accidental Injury or Illness resulting from a motor vehicle accident. However, these benefits are subject to the terms, conditions, and limits set forth in this Policy.

In addition, the motor vehicle insurance policy may provide for secondary benefits in accordance with regulations issued by the Department of Insurance.

If there is a dispute as to primacy between the motor vehicle insurance policy and this Policy, this Policy will be primary.

This order of benefit determination does not apply if You are enrolled in a government health benefit program which provides that it is always secondary, or otherwise will not be a primary provider of benefits for motor vehicle injuries.

STATEMENTS

No statement will avoid the coverage, or be used in defense of a claim under this Policy, unless it is contained in writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 A.M. on the date he attains the Policy's age limit, or marries, or when a step-child is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when the Policyholder's coverage ends.

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 A.M. Eastern Standard Time.

This Policy will be renewed automatically each year on the Anniversary Date, unless the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan;
(e) cancellation or amendment by the Board of this basic health benefit plan.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Members.

THE ROLE OF YOUR PRIMARY CARE PHYSICIAN

Your Primary Care Physician provides basic health maintenance services and coordinates Your overall health care. Anytime You need medical care, contact Your Primary Care Physician and identify Yourself as a Member of this program.

In a Medical Emergency, You may go directly to the emergency room. If You do, then call Your Primary Care Physician and Member Services within 48 hours. If You do not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage Your treatment for a Mental or Nervous Disorder, Substance Abuse, or Alcoholism. You must contact the Care Manager or Your Primary Care Physician when You need treatment for one of these conditions.]

EXHIBIT G

APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN FOR INDIVIDUALS AND FAMILIES

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c.161.
2. You and any family members whom you wish to cover must be New Jersey residents.
3. You and any family members you wish to cover must not be eligible to be covered or actually covered under:
   (a) a group health benefits plan that provides same or similar coverage for hospital and medical expenses;
   (b) Medicare; or
   (c) Medicaid.
4. Please note that benefits under this plan may be reduced if the benefits are also covered under another individual health benefits plan.
5. The effective date of your coverage shall be no later than the first of the month following the month in which the completed application was dated (and premium payment is received).

INDIVIDUAL APPLICATION INSTRUCTIONS

COMPLETE ALL SECTIONS IF YOU ARE:

1. [Applying] [Enrolling] as a new [insured] [enrolled] [subscriber].
2. Changing dependent coverage.

[COMPLETE SECTIONS 1, 2, 3, [5] AND [6] IF YOU ARE TERMINATING YOUR COVERAGE.

Section 1—Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide sex, date of birth, and social security number for each individual listed. If a dependent is a full-time college student, you **must** attach a current course schedule or tuition receipt. If a dependent is beyond age 20 or 23, as applicable, but is mentally or physically handicapped, unmarried and chiefly dependent upon the applicant or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked **only** if you wish to add or remove a dependent from the plan.

Section 2—Complete all information.

Section 3—Check box(es) indicating options for coverage, type of contract, [payment plan] and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4—This information is required. Please complete all information.

[Section 5—From the appropriate directory, choose the location number for a primary physician [or Center] (required for **all** members), GYN (if applicable). Check the change block only if you are changing providers.]

Section [5/6]—Applicant **must sign** this section and date this form for any activity or it will not be processed.

Section [6/7]—This information may be supplied voluntarily. Check appropriate box.

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by (carrier) after a review of the application [and receipt of payment].
2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under twenty (20) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of twenty (20) and twenty-three (23) who are full-time students at an accredited educational institution and receive at least half of their support from applicant and/or applicant's spouse and neither applicant's spouse nor children are eligible for group health benefits coverage.
3. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Individual Contract.
4. The Individual Contract will determine the rights and responsibilities of [insured(s)] [enrollee(s)] [subscriber(s)] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.

[5. As a condition to benefits, applicant understands and agrees that (with the exception of emergency procedures as defined in the Individual Contract) all services, in order to be covered by (Carrier), must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician.]

[6. Applicant agrees to make payment directly to health care providers such copayments as are provided for in the Individual Contract.]

[7. Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular [Center], primary care physician or other health care provider.]

[8. Applicant acknowledges that (Carrier's) participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of (Carrier).]

Please print in ink all information requested on this application.

1. Eligible Persons to be Enrolled (Note: Dependent children may be covered under their parent's contract only while unmarried and until the end of the calendar year in which they reach age 20 or 23, if full-time students. Unmarried and mentally and physically handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.

This section must be completed in its entirety.

LAST NAME	FIRST NAME	MI	BIRTHDATE MO	DAY	YR	SEX (M or F)	Social Security Number
Applicant 1. ☐ Add ☐ Remove							__/__/__-__/__-__/__/__
Spouse 2. ☐ Add ☐ Remove							__/__/__-__/__-__/__/__
Child 3. ☐ Add ☐ Remove							__/__/__-__/__-__/__/__
Child 4. ☐ Add ☐ Remove							__/__/__-__/__-__/__/__
Child 5. ☐ Add ☐ Remove							__/__/__-__/__-__/__/__

**Attach sheet to list additional children. Attach proof if full-time student. Totally disabled dependent children will be covered regardless of age. Attach proof of disability.*

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at another address? ☐ Yes ☐ No

If yes, who and at what address?

_____

Explain the circumstances.

_____

If any dependent's last name is different from yours, explain the circumstances.

_____

2. PRIMARY RESIDENCE

Street Apt. City State Zip

TELEPHONE NUMBER

Home ( ) - Work ( ) - Best place to call during day: ☐ Home ☐ Work

Are you a resident of the State of New Jersey? ☐ Yes ☐ No

Do you maintain a residency in any other state? ☐ Yes ☐ No

If "Yes", (a) Name of state _____

(b) How much time do you spend there each year? _____

3. COVERAGE (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY FAMILY) IN: *(Only one may be selected.)*

[PLAN A ( )
PLAN B ( ) Deductible $250 ____ $500 ____ $1000 ____
PLAN C ( ) Deductible $250 ____ $500 ____ $1000 ____
PLAN D ( ) Deductible $250 ____ $500 ____ $1000 ____
PLAN E ( ) Deductible $150 ____ $500 ____ $1000 ____]

[HMO Plan [$10] $15 [$20] copayment.]

Type of Contract: ☐ Single

[☐ Family]

[☐ Parent & Child(ren)]

[☐ Husband/Wife]

Type of Activity:

☐ New Subscriber

☐ Add/Remove Dependent
Reason _____
Date of Event _____

☐ Name Change From/To _____

[☐ Change of Primary or GYN]

☐ Withdrawal From Coverage
Date Of Event _____

SELECT THE PAYMENT PLAN YOU DESIRE

☐ Monthly ☐ Quarterly

4. OTHER HEALTH CARE COVERAGE (Please note that, in some situations, if you are eligible for other health benefits coverage, you are not eligible for this policy.)

Are you employed? ☐ Yes ☐ No If yes, please give name and address of your employer.
Are you eligible for other health benefits coverage? ☐ Yes ☐ No *(i.e., coverage under your employer's health benefits coverage, Medicare or Medicaid)*
If yes, give name and policy no. of other carrier or type of coverage.
Are other family members eligible for coverage? If yes, specify.
Are you replacing existing coverage? ☐ Yes ☐ No
If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy.

5. PROVIDER SELECTION

	[CENTER] CHANGE	PRIMARY OFFICE NO.	GYN OFFICE NO.
1. Applicant	☐		

Spouse	2.	☐		
Child	3.	☐		
Child	4.	☐		
Child	5.	☐		

]

[5.][6.] AUTHORIZATION AND CERTIFICATION

I hereby apply to (carrier) for coverage for any eligible dependents listed above and myself.

I understand that for the 12 months following the effective date of this policy, benefits are not provided for health care services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this policy. (Note: This limitation may not apply if the eligible person transfers from another health benefits plan.)

[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, (carrier) may pay the health care benefits directly to the provider instead of to me.]

I agree that: (a) any physician, hospital or other provider is authorized to provide to (carrier or its assignee) information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to (carrier or its assignee.)

I state that: (a) I am a resident of New Jersey, (b) the information given on this application is complete to the best of my knowledge and belief and (c) that (carrier) will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application (carrier) can cancel this contract as of the original effective date.

Applicant's Signature: _____ Date Signed: _____

Preparer's Signature: _____ DOI License # _____ Date Signed: _____

NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your [certificate][contract][policy]. It becomes part of your contract with us.

[6.][7.] INCOME HOUSEHOLD

You do not need to fill out this section. The information will be used for statistical purposes only, in a way that will not identify you personally. This information will not affect your application, acceptance or coverage.

☐ under $10,000 ☐ $20-30,000 ☐ $30-40,000 ☐ $40-50,000 ☐ $50 - $60,000

☐ $60,000 and above

IHCAS - 6/93

EXHIBIT H

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single Married Other / Employed Full-Time Student Part-Time Student	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM / MM DD YY TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM / MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 3. 2. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $

SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
SIGNED ____ DATE ____		PIN# / GRP#

ST11786 HCFA-1500 (LASER 12-90 OCR BC)

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

EXHIBIT I

1	2	3 PATIENT CONTROL NUMBER	
	5 BC/BS PROV. NO	6 FEDERAL TAX NO.	7 MEDICARE NO.	8 MEDICAID NO.	9
10 PATIENT'S LAST NAME FIRST NAME INITIAL	11 PATIENT'S ADDRESS CITY STATE ZIP				
12 BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR.	17 TYPE	18 SRC	19 A.H.	20 D.H.	21 STAT.	22 STATEMENT COVERS PERIOD FROM THROUGH	23 COV.D.	24 N-C.D.	25 C-I.D.	26 L-R.D.	27

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

34	CONDITION CODES 35	36	37	38	39	BLOOD RECORD (PINTS) 40 FURN	41 REPL.	42 NOT RP	43 DED.	44 SP. PROG.	45

	46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT
a								
b								

50 DESCRIPTION	51 R.CODE	52 S.UNITS	53 TOTAL CHARGES	54	55	56

57 PAYER	58 REL. TO ASG. INFO. BEN.	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST. RESPONSIBLITY	63 PRIOR PAYMENTS	64 EST. AMOUNT DUE
A						
B						
C						

DUE FROM PATIENT ▶

65 INSURED'S NAME	66 SEX	67 P REL.	68 CERT.-SSN-HIC-ID NO.	69 GROUP NAME	70 INSURANCE GROUP NO.
A					
B					
C					

71 EID	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID.	75 EMPLOYER LOCATION

NOTICE TO THE PATIENT

The hospital is acting solely as an agent for the patient in filing for insurance benefits assigned to it, however, the hospital can assume no responsibility for guaranteeing payment of covered charges as shown on the face of the bill. Credit is shown only when the hospital has actually received payment. Should an overpayment be made, a refund check will be sent to the authorized party that is due the overpayment.

UB-82 HCFA-1450

EXHIBIT J

Loss Ratio Report Form

New Jersey Individual Health Coverage Program

Calendar Year Ending December 31, _____

*Name of Carrier:_____ NAIC #_____

Address: _____

_____

*A separate Report Form should be completed and filed for each affiliate.

A. Net Earned Premium for Standard Health Benefits Plans $_____

B. Losses

1. Claims incurred during calendar year and paid through June 30, _____ $_____
2. Residual Reserve (a or b)
   a. Safeharbor reserve (3.3% of B1) $_____
   b. Calculated residual reserve (enclose required actuarial certification) $_____
3. Pro rata share of assessments $_____
4. Total Losses (Either 1 + 2a + 3 or 1 + 2b + 3) $_____

C. Loss Ratio (B ÷ A) _____%

If C is less than 75%, then a plan must be included for returns of the difference to policy and contract holders.

I certify that the above information is accurate, complete and has been prepared in accordance with N.J.S.A. 17B:27A-9e(1) and (2) and N.J.A.C. 11:20-7.

_____ _____

Date Actuary's Signature

_____

Title

_____

Telephone Number

EXHIBIT K

New Jersey Individual Health Coverage Program
Carrier Market Share and Net Paid Loss Report

This Report must be completed in accordance with the provisions of N.J.A.C. 11:20-8, and certified to by the Chief Financial Officer or other duly authorized officer of the Carrier. In 1993 Reports must be completed and returned on or before June 28, 1993. Thereafter, Reports must be completed and returned on or before March 1 annually. Completed Reports must be returned to:

Interim Administrator, IHC Program
c/o The Prudential Insurance Co. of America
P.O. Box 4080
Iselin, NJ 08830

Fax number (908) 632-7409.

Part A. Carrier Information

1. Carrier's Name:_____
2. Carrier's NAIC Number (including Group):_____
3. Is the specifically-named Carrier an affiliated Carrier?

_____ Yes _____ No

a. If Yes, is this Report the combined Report for all Affiliated Carriers, or for the specifically-named Carrier?

_____ All Affiliated Carriers' combined Report
_____ Specifically-named Carrier's separate Report

b. If for all Affiliated Carriers, indicate the number of specifically-named Carrier Reports attached to this combined Report. _____

Part B. Personal Respondent Information

1. Name:_____

2. Title:_____

3. Telephone No:_____ Facsimile No: _____

Part C. Calendar Year Information for _____
(year)

1. Net earned premium for all group and individual health benefits plans: $ _____

2. Number of non-group persons enrolled by the Carrier:

   a. Community rated and modified community rated persons _____
   b. Community rated conversion policy persons _____
   c. Medicare cost and risk persons _____
   d. Medicaid recipients _____
   e. HealthStart Plus recipients _____

   Non-group Total _____

3. Net paid loss report for Individual Health Benefits Plans:

   a. PREMIUM EARNED
   Community rated and modified community rated $

   b. CLAIMS PAID (–)
   Community rated and modified community rated $

   c. EXPENSES (–)
   Community rated and modified community rated $

   d. SUBSIDIES (+)
   (BCBSNJ only; 1992 only)

   e. NET INVESTMENT INCOME (+)
   Community rated and modified community rated $

   f. NET PAID GAIN/(LOSS)
   Community rated and modified community rated $ _____

   g. REIMBURSEMENT SOUGHT $ _____
   (For 1992: Limited to the Lesser of $10,000,000 or 50% of the Net Paid Loss)

Part D. Certification

I certify that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provision of N.J.A.C. 11:20-8.

_____ _____ _____
Signature Title Date

PUBLIC NOTICES

EDUCATION

(a)

THE COMMISSIONER

Notice of Public Hearings
State Plan for the Education of Children with Educational Disabilities

Take notice that the New Jersey Department of Education, Division of Special Education will receive public comment on amendments to the State Plan under the Education of Individuals with Disabilities Act for fiscal years 1992 through 1994. This revision is a required submission under the Act. The Federal Office of Special Education and Rehabilitation Services (OSERS) in the United States Department of Education must approve the State Plan prior to authorizing Part B funds for special education services to the State of New Jersey.

Copies of the 1992-94 State Plan may be obtained from the 21 offices of the county superintendents of schools. Appendices are available for review at the Office of Special Education Programs, 240 West State Street, New Jersey. If you wish to review the appendices, contact Carol Kaufman at the address/telephone below.

Interested agencies, organizations and individuals are invited to comment on the proposed State Plan amendments, program and/or to allege a failure to comply with applicable statutes and/or regulations.

The **public comment period** on the State Plan amendments is July 6, 1993 to August 6, 1993. **Public hearings** will be held from 3:00 P.M. to 5:00 P.M. as follows:

Tuesday, July 27, 1993
Gloucester County Office of Education
R.R. #4, Box 184D
Sewell, NJ 08080
(609) 468-6500

Wednesday, July 28, 1993
Bergen County Office of Education
327 East Ridgewood Avenue
Paramus, NJ 07652
(201) 599-6256

Thursday, July 29, 1993
Middlesex County Office of Education
200 Old Matawan Road
Old Bridge, NJ 08857
(908) 390-6000

These hearings are not in relation to the Plan to Revise Special Education in New Jersey. Public comment on the Plan to Revise will be taken in separate hearings.

If you wish to comment on the proposed State Plan amendments, you may request an opportunity to testify or you may send your written comment to:

Carol Kaufman
Office of Special Education Programs
CN 500
Trenton, New Jersey 08625
(609) 292-7605

The State Plan amendments will be revised following a review of the public comments.

ENVIRONMENTAL PROTECTION AND ENERGY

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Atlantic County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Atlantic County Water Quality Management (WQM) Plan. This amendment proposal was submitted on behalf of Harbor Pines Golf Course, formerly known as The Gurwicz Tract. This amendment will modify the Egg Harbor Township Wastewater Management Plan (WMP) by expanding the sewer service area to serve Block 54E, Lots 4, 5, 12-14, 15, 16-22, 26, 27, 29-36, 38, 40, 52-59, and 61. The expansion will serve 290 single family residences and an eighteen hole golf course. The site totals 484 acres of which 122 are wetlands. There will be a clubhouse containing approximately 10,000 square feet on the premises. The wastewater flow will be conveyed to the Atlantic County Utility Authority—City Island Sewage Treatment Plan (STP). The project is located in a "Limited Growth Area" of the Coastal Zone.

This notice is being given to inform the public that a plan amendment has been proposed for the Atlantic County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the Office of Policy, Planning, and Economic Development, County Office Building, 1333 Atlantic Avenue, Atlantic City, New Jersey 08401, and the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, New Jersey 08625. These documents are available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling either the Office of Land and Water Planning at (609) 633-1179 or the Atlantic County Office of Policy, Planning, and Economic Development at (609) 345-6700.

The Atlantic County Office of Policy, Planning, and Economic Development will hold **a public hearing** on the proposed WQM Plan amendment. The public hearing will be on Wednesday, August 18, 1993 at 11:00 A.M. in the Fourth Floor Conference Room of the County Office Building in Atlantic City. **Interested persons** may submit written comments on the proposed amendment to Mr. Lauren Moore at the County Office Building address cited above with a copy sent to Dr. Daniel J. Van Abs, at the NJDEPE address cited above. All comments must be delivered within 15 days after the close of the public hearing. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered with respect to the amendment request. Atlantic County and the NJDEPE thereafter may approve and adopt this amendment without further notice. The Atlantic County Planning Advisory Board shall issue a recommendation on the WQM Plan amendment to the County Executive and the Chairman of the Board of Chosen Freeholders. An amendment adoption shall be incorporated into the Atlantic County WQM Plan only upon adoption of an ordinance by the Atlantic County Board of Chosen Freeholders, and adoption of the amendment by the NJDEPE.

(c)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Sussex County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Sussex County Water Quality Management (WQM) Plan. The amendment proposal has been submitted by the Sussex County Department of Planning and Development. This amendment proposes

a new wastewater treatment system discharging to ground water to serve the proposed Skylands Park Management 4,200 seat minor league baseball stadium and 24,000 square foot museum/sports complex in Frankford Township, Sussex County. A Wastewater Recycling and Treatment System is proposed to treat the projected wastewater flow of 24,000 gallons per day. This amendment would update the Frankford Township Wastewater Management Plan.

This notice is being given to inform the public that a plan amendment has been proposed for the Sussex County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the Sussex County Department of Planning and Development, Division of Environmental Resource Planning, County Administration Building, P.O. Box 709, Newton, New Jersey 07860; and the NJDEPE, Office of Land and Water Plannning, CN423, 401 East State Street, Trenton, New Jersey 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling either the Office of Land and Water Planning at (609) 633-1179 or the Sussex County Department of Planning and Development at (201) 579-0500.

The Sussex County Board of Chosen Freeholders will hold **a public meeting** on the proposed Sussex County WQM Plan amendment at which time all interested persons may appear and shall be given an opportunity to be heard. The public meeting will be held on Wednesday, August 11, 1993 at 2:10 P.M. in the Freeholder meeting room, County Administration Building, Plotts Road, Newton, New Jersey. **Interested persons** may submit written comments on the amendment to Mr. George Krauss, Sussex County Department of Planning and Development, at the address cited above, with a copy sent to Dr. Daniel J. Van Abs, Office of Land and Water Planning, at the NJDEPE address cited above. All comments must be submitted within 15 days following the public meeting. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by the Sussex County Board of Chosen Freeholders with respect to the amendment request. In addition, if the amendment is adopted by Sussex County, the NJDEPE must review the amendment prior to final adoption. The comments received in reply to this notice will also be considered by the NJDEPE during its review. Sussex County and the NJDEPE thereafter may approve and adopt this amendment without further notice.

HEALTH

(a)

OFFICE OF MINORITY HEALTH

Notice of Availability of Grants Health Promotion/Disease Prevention—Minority Health Education and Outreach

Take notice that, in compliance with N.J.S.A. 52:14-34.4 et seq. (P.L. 1987, c.7), the Department of Health hereby publishes notice of the availability of the following grant:

Name of grant program: Health Promotion/Disease Prevention-Minority Health Education and Outreach, Grant Program No. 94-72-OMH.

Purpose for which the grant program funds will be used: To support the development of innovative community based health promotion/disease prevention and health status assessment projects targeting racial/ethnic minorities (for example, African Americans, Latino, Asian/Pacific Islanders, American Indian, and others) and medically underserved populations.

Amount of money in the grant program: The availability of funds for this program is contingent on appropriation of funds to the Department. Contact the person identified in this notice to determine whether the funds have been awarded and to receive further information.

Eligible applicants must comply with the following requirements: 1. Terms and conditions for the administration of health service grants; 2. General and specific grant compliance requirements issued by the granting agency; and 3. Applicable federal cost principles relating to the applicant.

Group or entities which may apply for the grant program: Non-profit, community based agencies and organizations (with 501(C)(3)) status which predominantly serve racial/ethnic minorities (that is, greater than 51 percent of service population).

Qualifications needed by an applicant to be considered for the grant: Demonstrated history and understanding of the health needs of minority populations, and the ability to provide creative culturally, ethnically and linguistically appropriate services. Applicants must also demonstrate how they propose to provide services and/or project activities in close proximity to minority communities.

Procedures for eligible entities to apply for grant funds: Complete and submit an original and six typed copies of New Jersey Department of Health Application for Health Service Grant.

For Information Contact:

Gilbert O. Ongwenyi, M.S., CHES, Coordinator,
Programmatic/Fiscal Management
New Jersey Department of Health
Office of Minority Health
CN 360
Trenton, NJ 08625-0360
(609) 292-6962

Deadline by which applications must be submitted: Varies by grant. Information will be included in formal request for application.

Date by which applicant shall be notified whether they will receive funds: Applicant will be notified approximately 30 days prior to start date of grant.

(b)

OFFICE OF MINORITY HEALTH

Notice of Availability of Grants Minority Community Outreach—Minority Health Month

Take notice that, in compliance with N.J.S.A. 52:14-34.4 et seq. (P.L. 1987, c.7), the Department of Health hereby publishes notice of the availability of the following grant:

Name of grant program: Minority Community Outreach—Minority Health Month, Grant Program No. 94-71-OMH.

Purpose for which the grant program funds will be used: To support the development of community outreach activities designed to highlight Minority Health Month, September 1994. Examples of activities that may be considered for funding are: health education/information outreach projects, cross-cultural diversity awareness, and minority health promotion conference or symposiums.

Amount of money in the grant program: The availability of funds for this program is contingent on appropriation of funds to the Department. Contact the person identified in this notice to determine whether the funds have been awarded and to receive further information.

Eligible applicants must comply with the following requirements: 1. Terms and conditions for the administration of health service grants; 2. General and specific grant compliance requirements issued by the granting agency; and 3. Applicable federal cost principles relating to the applicant.

Group or Entities which may apply for the grant program: Non-profit, community based agencies and organizations (with 501(C)(3) status) which predominantly serve racial/ethnic minorities (that is, greater than 51 percent of service population).

Qualifications needed by an applicant to be considered for the grant: Demonstrated history and understanding of the health needs of minority populations, and the ability to provide creative culturally, ethnically and linguistically appropriate services. Applicants must also demonstrate how they propose to provide services and/or project activities in close proximity to minority communities.

Procedures for eligible entities to apply for grant funds: Complete and submit an original and six typed copies of New Jersey Department of Health Application for Health Service Grant.

For Information Contact:

Gilbert O. Ongwenyi, M.S., CHES, Coordinator,
Programmatic/Fiscal Management
Office of Minority Health
New Jersey Department of Health
CN 360
Trenton, NJ 08625-0360
(609) 292-6962

Deadline by which applications must be submitted: Varies by grant. Information will be included in formal request for application.

Date by which applicant shall be notified whether they will receive funds: Applicant will be notified approximately 30 days prior to start date of grant.

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS STATE BOARD OF PROFESSIONAL ENGINEERS AND LAND SURVEYORS

Notice of Receipt of Petitions for Rulemaking

N.J.A.C. 13:40

Petitioner: T.S. Madson II, Executive Director, New Jersey Land Surveyor's Council.

Take notice that on April 22, 1993, the State Board of Professional Engineers and Land Surveyors received 18 petitions for rulemaking from T.S. Madson II, Executive Director of the New Jersey Land Surveyor's Counsel ("petitioner").

Petitioner asserts that Board licensees are engaging in acts which are a clear and present danger to the health, welfare, safety and property of the people of New Jersey. Petitioner requests administrative rules, as set forth below, which would create new standards of practice that are necessary, in petitioner's view, to assure that licensees of this Board render proper professional services for the protection of the public health, safety and welfare.

Petitioner requests that the Board take the following rulemaking actions:

1. Define the practice of land and boundary surveying.
2. Bring the definition of the practice of land and boundary surveying into conformance with current practice in the State of New Jersey.
3. Prohibit illegal "deed plot surveys" used for the purpose of circumventing the requirement for a full boundary survey.
4. Require a drawing on all surveys.
5. Require licensees to be financially responsible for damages caused by their surveys.
6. Require questions on the land surveyor's licensing examination to be relevant to land surveying practice in New Jersey and to constitute a minimum level of competence necessary to practice in New Jersey.
7. Specify treble damages for a land surveyor registrant's failure to meet the requirements of the Minimum Technical Standards as a way to charge reduced fees.
8. Require that a registered land surveyor physically participate in the field work in order for a land survey to be legally valid.
9. Authorize standard letters from the Board requesting that offending or potentially offending activities cease and desist.
10. Specify injunctive relief for negligence per se violations.
11. Prohibit illegal surveying re-certifications.
12. Define the necessity for a land or boundary survey in every real property conveyance and/or financial transaction where that real property is to be used as collateral for any loan or mortgage.
13. Prohibit the act of illegally sub-contracting survey field and office work to technicians.
14. Define the length of time that a land survey is legally valid.
15. Acknowledge receipt of all correspondence and notify any and all affected parties within five working days following Board action on any matter.
16. Define the unauthorized practice of land surveying by non-surveyors to be the execution of any survey-related document.
17. Prohibit use of the illegal "Wash-Out Survey."
18. Require licensed land surveyors to demonstrate, every four years, a minimal level of competence to practice land surveying.

A copy of this notice has been mailed to the petitioner, as required by N.J.A.C. 1:30-3.6.

(b)

DIVISION OF CONSUMER AFFAIRS STATE BOARD OF REAL ESTATE APPRAISERS

Notice of Receipt of Petitions for Rulemaking and Action Thereon

N.J.A.C. 13:40A

Petitioner: T.S. Madson II, Executive Director, New Jersey Land Surveyor's Council.

Take notice that on April 22, 1993, the State Board of Real Estate Appraisers received 12 petitions for rulemaking from T.S. Madson II, Executive Director of the New Jersey Land Surveyor's Counsel ("petitioner").

Petitioner asserts that Board licensees are engaging in acts which are a clear and present danger to the health, welfare, safety and property of the people of New Jersey. Petitioner requests administrative rules, as set forth below, which would create new standards of practice that are necessary, in petitioner's view, to assure that licensees of this Board render proper professional services for the protection of the public health, safety and welfare.

Petitioner requests that the Board take the following rulemaking actions:

1. Prohibit use of the Owner's Survey Affidavit and Indemnification Agreement in lieu of a correct survey.
2. Require a real estate appraiser to use a current land or boundary survey less than 90 days old as the basis for an appraisal of any property to be used as collateral for any financial transaction or mortgage.
3. Define land or boundary surveys and require that such be performed by a land surveyor registered pursuant to the laws stated within the New Jersey statutes.
4. Prohibit use of the "sketch of description map" in lieu of a full, current and correct survey.
5. Prohibit use of any land or boundary survey without an accompanying map, plat, drawing or sketch which meets the requirements of the New Jersey Minimum Technical Standards.
6. Provide treble damages for licensees who do not take reasonable care when purchasing, soliciting for, receiving or using any land or boundary survey which fails to meet the New Jersey Minimum Technical Standards.
7. Define the fiduciary duty of a licensee when ordering or advising a client about ordering a land or boundary survey.
8. Provide that any licensee attempting to set prices for land or boundary surveys becomes jointly and severally liable for the resultant survey with the surveyor who performs such survey.
9. Require that Board licensees take reasonable care to assure that payment has been made for a current land or boundary survey prior to release of the real property appraisal.
10. Prohibit use of any land or boundary survey over 90 days old for the purposes of conveying or mortgaging real property.
11. Acknowledge receipt of all correspondence and notify any and all affected parties within five working days following Board action on any matter.
12. Prohibit the purchase, promotion or use of any Wash-Out Survey on any basis.

Take further notice that the Board reviewed these petitions at its May 11, 1993 meeting and determined that additional time was needed to study and evaluate petitioner's positions. Accordingly, the Board voted to refer the petitions to a subcommittee for further analysis and, if necessary, meetings with the State Board of Professional Engineers and Land Surveyors. The Board anticipates that it will conclude its deliberations and respond to the petitioner on or before October 1, 1993.

A copy of this notice has been mailed to the petitioner, as required by N.J.A.C. 1:30-3.6.

TRANSPORTATION

(a)

DIVISION OF ROADWAY DESIGN
BUREAU OF UTILITIES AND RAILROAD ENGINEERING

Notice of Public Hearing
Designation of At-grade Crossing as an "Exempt Crossing"
Jersey Avenue (N.J. Route 91), North Brunswick Township, Middlesex County

Take notice that the State of New Jersey, Department of Transportation is scheduling a public hearing on a recommendation it has received to designate a proposed new at-grade railroad crossing on Jersey Avenue (N.J. Route 91) in North Brunswick Township, Middlesex County as an "Exempt Crossing." The proposed at-grade crossing will replace the present at-grade crossing on Jersey Avenue (N.J. Route 91) which serviced the A.C. Delco building.

In accordance with New Jersey Motor Vehicles and Traffic Regulations N.J.S.A. 39:4-128, the Commissioner of Transportation can designate an at-grade railroad crossing as an "Exempt Crossing."

The "Exempt Crossing" designation exempts the driver of any omnibus, designed for carrying more than six passengers, or of any school bus carrying any school child or children, or of any vehicle carrying explosive substance or flammable liquids as a cargo or part of a cargo, from stopping before crossing at the tracks of a railroad. Normally the above such vehicles must come to a complete stop before proceeding across the crossing.

A Diagnostic Team has determined that at the proposed at-grade crossing the potential for damage and injury from accidents between motor vehicles required to stop at grade crossings and other vehicles traveling in the same direction exceeds that between a train and the vehicles required to stop by law.

The **public hearing** will be held on:

Wednesday, July 28, 1993
in the Council Conference Room at the
North Brunswick-Township Municipal Building
710 Herman Road
North Brunswick Township
Time: 4:00 P.M. to 6:00 P.M.
7:00 P.M. to 9:00 P.M.

Persons wishing to make oral presentation are asked to limit their comments to a three to five minute time period. Presenters should bring a copy of their comments to the hearing for use by the Department. A record of the hearing will be made. The hearing record will be kept open for a period of seven days following the date of the public hearing.

Interested persons may submit written comments until August 6, 1993 to:

Donna Troiano, P.E.
Manager, Bureau of Utility and
Railroad Engineering
New Jersey Department of Transportation
CN 600
Trenton, New Jersey 08625

OTHER AGENCIES

(b)

HACKENSACK MEADOWLANDS DEVELOPMENT COMMISSION

Notice of Receipt of Petition for Rulemaking
Official Zoning Map
N.J.A.C. 19:4-6.28

Petitioners: G&S Motors Equipment Co., Inc., and
Joseph Supor.
Authority: N.J.S.A. 13:17-1 et seq.

Take notice that on June 4, 1993, petitioners completed a petition with the Hackensack Meadowlands Development Commission requesting an amendment to N.J.A.C. 19:4-6.28, the Official Zoning Map.

Specifically, petitioners are requesting a rezoning of Block 286, Lots 38, 39, and 40, in Kearny, New Jersey, from SU-3 Specially Planned Area to Light Industrial & Distribution "B." The site is presently bounded immediately to the west by PSE&G high tension wires, to the south by PSE&G gas lines, and to the north and east by active railroad lines. The 7.8 acre tract has access from the Newark and Jersey City Turnpike, a major arterial road. One of the petitioners operates a transformer disposal and rebuilding facility on one of the parcels. The remaining parcels are vacant.

After due notice, this petition will be considered by the Hackensack Meadowlands Development Commission in accordance with the provision of N.J.S.A. 13:17-1 et seq.

(c)

ELECTION LAW ENFORCEMENT COMMISSION

Notice of the Availability of the Quarterly Report of Legislative Agents for the First Quarter of 1993, Ending March 31, 1993

Take notice that Frederick M. Herrmann, Executive Director of the Election Law Enforcement Commission, in compliance with N.J.S.A. 52:13C-23, hereby publishes Notice of the Availability of the Quarterly Report of Legislative Agents for the first quarter of 1993, accompanied by a Summary of the Quarterly Report.

At the conclusion of the first quarter of 1993, the Notices of Representation filed with this office reflect that 550 individuals are registered as Legislative Agents. Legislative Agents are required by law to submit in writing a Quarterly Report of their activity in attempting to influence legislation and regulation during each calendar quarter. The aforesaid report shall be filed between the first and tenth days of each calendar quarter.

A complete Quarterly Report of Legislative Agents, consisting of the summary and copies of all Quarterly Reports filed by Legislative Agents for the first calendar quarter of 1993, has been filed separately for reference with the following offices: the Office of the Governor, the Office of the Election Law Enforcement Commission, the Office of Legislative Services, and the State Library. Each is available for inspection in accordance with the practices of those offices.

The Summary Report includes the following information:

- The names of registered Agents, their registration numbers, their business addresses and whom they represent.
- A list of Agents who have filed Quarterly Reports by statutory and compilation deadlines for this quarter.
- A list of Agents whose Quarterly Reports were not received by the compilation deadline for this quarter.

Following is a listing of all new Legislative Agents who have filed Notices of Representation during the first calendar quarter of 1993:

No. 756-11 Nancy Goldhill representing Legal Services of NJ, Inc.
No. 756-8 Stephen St. Hilaire representing Legal Services of NJ, Inc.
No. 756-9 David Sciarra representing Legal Services of NJ, Inc.
No. 756-10 Robin C. Frey representing Legal Services of NJ, Inc.
No. 835-1 Susan G. Roth, Ed.D representing Bonnie Brae
No. 835-2 Thomas A. Iorizzo representing Bonnie Brae
No. 836-1 Dorothy P. Bowers representing Merck & Co., Inc.
No. 837-1 Joel P. Harris representing NJ State Fireman's Mutual Benevolent Ass'n
No. 838-1 Willard S. Ward representing Monsanto Co.
No. 839-1 Phyllis Salvato-Cole representing Garden State Pharmacy Owners, Inc.
No. 840-1 Peter M. Yaffe representing Waste Management Inc.
No. 841-1 Glenn Roberts representing Daniel R. Thompson, P.C.
No. 842-1 Richard W. Hayden representing Waste Management Inc.
No. 843-1 Dennis M. Culnan representing Phoenix Strategies
No. 844-1 Charles G. Williams representing Burroughs Wellcom Co.
No. 845-1 Robert A. Briant, Jr. representing Utility & Transportation Contractors Ass'n
No. 846-1 Steven G. Changaris representing National Solid Waste Management Ass'n
No. 847-1 Debra A. Hart representing Association Associates Inc.

No. 848-1 Richard Dunk representing Jersey Central Power & Light Co.
No. 848-2 Leigh C. Kline representing Jersey Central Power & Light Co.
No. 849-1 George J. Albanese, Independent Lobbyist
No. 850-1 Glenn E. Dooley, Sr. representing Warner-Lambert Co.
No. 851-1 Julie Turner representing NJ Ass'n of Children's Residential Facilities
No. 261-2 Jeffrey H. Siegell representing Exxon Research & Engineering Co.
No. 852-1 Karen J. Kominsky representing Great Swamp Watershed Ass'n
No. 853-1 Robert Angelo representing SEIU Local 518
No. 168-3 Joseph M. Clayton, Jr. representing NJ Land Title Insurance Ass'n.
No. 583-8 Monica Walsh representing Public Policy Advisors, Inc.
No. 854-1 Barbara L. Pancari representing Atlantic Electric
No. 855-1 Betty F. Greitzer representing NJ Academy of Audiology
No. 856-1 Arthur E. Chalker representing DuPont Merck Pharmaceutical Co.
No. 857-1 James G. Leavey representing NJ State Law Enforcement Officers Ass'n
No. 858-1 Lynn Strickland representing Garden State Coalition of Schools
No. 463-6 John W. Koehn representing the client list of Issues Management
No. 268-2 M. Gene Pollard representing CWA
No. 651-2 Ralph A. Dean representing NJ Hospital Ass'n
No. 22-8 Joan S. Fizulich representing the client list of LeBoeuf, Lamb, Leiby & MacRae
No. 859-1 Linda R. Petrino representing Family Planning Advocates of NJ
No. 860-1 Wayne D. Defeo representing Browning Ferris Industries
No. 861-1 Ronald L. Randy representing Ass'n of Environmental Authorities
No. 861-2 John C. Hall representing Ass'n of Environmental Authorities
No. 291-8 Herta A. Clements representing the client list of Nancy Becker & Associates
No. 862-1 Raymond Durkin representing Ass'n of Physical Fitness Centers
No. 335-4 Mary B. Wachtar representing NJ State Nurses Ass'n
No. 863-1 Patrick DeDeo representing Blue Cross & Blue Shield of NJ

Following is a listing of all Legislative Agents who have filed Notices of Termination during the first calendar quarter of 1993.

Legislative Agent	Registration Number
G. Oliver Papps	50-3
William J. Kohm	433-5
Sidney Ytkin	583-7
Edward G. Rosenblum, Esq.	732-1
Gail Levinson	740-1
Connie M. Pascale	756-6
Anthony E. Koester	173-9
Jay L. Cherry	351-1
Joseph W. Katz	7-1
Richard P. Visotcky	610-1
Elizabeth C. O'Donoghue	463-4
Debra A. Hart	196-1
Theresa A. Lillo	291-6
Maria Verducci-Florio	45-4
Monica Walsh	75-4
Donald M. Scarry	705-1
Jeanne M. Bratsafolis	173-7
Vincent J. Sharkey, Jr.	173-8
Brian Matthew Villa	269-1
Cynthia R. Radick	155-3
Walter W. Chesner	155-1
William Applegate	606-1
John R. Weigel	168-2
Samuel P. Moulthrop	173-10
Irving I. Tecker	29-1
Marina Coredemus	812-1
Dale Franklin Hoover	747-1
Peter G. Sheridan	645-1
Reni Erdos	485-1

For further information, contact the staff of the Commission at (609) 292-8700.

REGISTER INDEX OF RULE PROPOSALS AND ADOPTIONS

The research supplement to the New Jersey Administrative Code

A CUMULATIVE LISTING OF CURRENT PROPOSALS AND ADOPTIONS

The **Register Index of Rule Proposals and Adoptions** is a complete listing of all active rule proposals (with the exception of rule changes proposed in this Register) and all new rules and amendments promulgated since the most recent update to the Administrative Code. Rule proposals in this issue will be entered in the Index of the next issue of the Register. **Adoptions promulgated in this Register have already been noted in the Index by the addition of the Document Number and Adoption Notice N.J.R. Citation next to the appropriate proposal listing.**

Generally, the key to locating a particular rule change is to find, under the appropriate Administrative Code Title, the N.J.A.C. citation of the rule you are researching. If you do not know the exact citation, scan the column of rule descriptions for the subject of your research. To be sure that you have found all of the changes, either proposed or adopted, to a given rule, scan the citations above and below that rule to find any related entries.

At the bottom of the index listing for each Administrative Code Title is the Transmittal number and date of the latest looseleaf update to that Title. Updates are issued monthly and include the previous month's adoptions, which are subsequently deleted from the Index. To be certain that you have a copy of all recent promulgations not yet issued in a Code update, retain each Register beginning with the May 3, 1993 issue.

If you need to retain a copy of all currently proposed rules, you must save the last 12 months of Registers. A proposal may be adopted up to one year after its initial publication in the Register. Failure to adopt a proposed rule on a timely basis requires the proposing agency to resubmit the proposal and to comply with the notice and opportunity-to-be-heard requirements of the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.), as implemented by the Rules for Agency Rulemaking (N.J.A.C. 1:30) of the Office of Administrative Law. If an agency allows a proposed rule to lapse, "Expired" will be inserted to the right of the Proposal Notice N.J.R. Citation in the next Register following expiration. Subsequently, the entire proposal entry will be deleted from the Index. See: N.J.A.C. 1:30-4.2(c).

Terms and abbreviations used in this Index:

N.J.A.C. Citation. The New Jersey Administrative Code numerical designation for each proposed or adopted rule entry.

Proposal Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of a proposed amendment or new rule.

Document Number. The Registry number for each adopted amendment or new rule on file at the Office of Administrative Law, designating the year of promulgation of the rule and its chronological ranking in the Registry. As an example, R.1993 d.1 means the first rule filed for 1993.

Adoption Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of an adopted amendment or new rule.

Transmittal. A series number and supplement date certifying the currency of rules found in each Title of the New Jersey Administrative Code: Rule adoptions published in the Register after the Transmittal date indicated do not yet appear in the loose-leaf volumes of the Code.

N.J.R. Citation Locator. An issue-by-issue listing of first and last pages of the previous 12 months of Registers. Use the locator to find the issue of publication of a rule proposal or adoption.

MOST RECENT UPDATE TO THE ADMINISTRATIVE CODE: SUPPLEMENT APRIL 19, 1993

NEXT UPDATE: SUPPLEMENT MAY 17, 1993

Note: If no changes have occurred in a Title during the previous month, no update will be issued for that Title.

N.J.R. CITATION LOCATOR

If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register	If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register
24 N.J.R. 2315 and 2486	July 6, 1992	25 N.J.R. 219 and 388	January 19, 1993
24 N.J.R. 2487 and 2650	July 20, 1992	25 N.J.R. 389 and 616	February 1, 1993
24 N.J.R. 2651 and 2752	August 3, 1992	25 N.J.R. 619 and 736	February 16, 1993
24 N.J.R. 2753 and 2970	August 17, 1992	25 N.J.R. 737 and 1030	March 1, 1993
24 N.J.R. 2971 and 3202	September 8, 1992	25 N.J.R. 1031 and 1308	March 15, 1993
24 N.J.R. 3203 and 3454	September 21, 1992	25 N.J.R. 1309 and 1620	April 5, 1993
24 N.J.R. 3455 and 3578	October 5, 1992	25 N.J.R. 1621 and 1796	April 19, 1993
24 N.J.R. 3579 and 3784	October 19, 1992	25 N.J.R. 1797 and 1912	May 3, 1993
24 N.J.R. 3785 and 4144	November 2, 1992	25 N.J.R. 1913 and 2150	May 17, 1993
24 N.J.R. 4145 and 4306	November 16, 1992	25 N.J.R. 2151 and 2620	June 7, 1993
24 N.J.R. 4307 and 4454	December 7, 1992	25 N.J.R. 2621 and 2794	June 21, 1993
24 N.J.R. 4455 and 4606	December 21, 1992	25 N.J.R. 2795 and 3050	July 6, 1993
25 N.J.R. 1 and 218	January 4, 1993		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
ADMINISTRATIVE LAW—TITLE 1				
1:13A-1.1, 14.2, 14.4, 18.1, 18.3	Lemon Law hearings	25 N.J.R. 2625(a)		
1:13A-1.2, 18.1, 18.2	Lemon Law hearings: exceptions to initial decision	24 N.J.R. 1843(a)	R.1993 d.289	25 N.J.R. 2247(a)
	Most recent update to Title 1: TRANSMITTAL 1992-5 (supplement November 16, 1992)			
AGRICULTURE—TITLE 2				
2:1-4	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1314(a)	R.1993 d.274	25 N.J.R. 2247(b)
2:1-4	Disability discrimination grievance procedure: administrative correction	————	————	25 N.J.R. 2859(a)
2:6	Animal health: biological products for diagnostic or therapeutic purposes	24 N.J.R. 2974(a)		
2:6	Animal health: extension of comment period regarding biological products for diagnostic or therapeutic purposes	24 N.J.R. 3981(a)		
2:23	Gypsy moth suppression program	25 N.J.R. 1627(a)	R.1993 d.305	25 N.J.R. 2686(a)
2:34-2.1, 2.2	Equine Advisory Board rules	25 N.J.R. 740(a)	R.1993 d.252	25 N.J.R. 2247(c)
2:71	Grades and standards	25 N.J.R. 1801(a)		
2:72	Bonding requirement of commission merchants, dealers, brokers, agents	25 N.J.R. 1802(a)		
2:74	Controlled atmosphere storage apples	25 N.J.R. 1803(a)		
2:76-2.1, 2.2, 2.3, 2.4	Recommendation of agricultural management practices	25 N.J.R. 622(a)	R.1993 d.223	25 N.J.R. 1963(a)
2:76-3.12, 4.11	Farmland preservation programs: deed restrictions on enrolled lands	25 N.J.R. 222(a)	R.1993 d.181	25 N.J.R. 1866(a)
2:76-6.2-6.11, 6.13, 6.16, 6.17	Farmland Preservation Program: acquisition of development easements	25 N.J.R. 1804(a)		
2:76-6.15	Agriculture Retention and Development Program: lands permanently deed restricted	25 N.J.R. 223(a)	R.1993 d.182	25 N.J.R. 1867(a)
2:76-10	Farmland Appraisal Handbook Standards	25 N.J.R. 1811(a)		
	Most recent update to Title 2: TRANSMITTAL 1993-2 (supplement February 16, 1993)			
BANKING—TITLE 3				
3:1-2.3, 2.5, 2.21	Depository charter applications and branch applications	25 N.J.R. 1033(a)	R.1993 d.258	25 N.J.R. 2248(a)
3:1-12.4	Multiple party deposit accounts: administrative correction	————	————	25 N.J.R. 2860(a)
3:1-14.5	Revolving credit equity loans	25 N.J.R. 1033(b)	R.1993 d.218	25 N.J.R. 1965(a)
3:1-16.2, 16.3	Fees; mortgage banker non-servicing	25 N.J.R. 2625(b)		
3:2-1.4	Mortgage banker non-servicing	25 N.J.R. 1035(a)	R.1993 d.295	25 N.J.R. 2687(a)
3:2-1.4	Mortgage banker non-servicing	25 N.J.R. 2625(b)		
3:3-3	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1314(b)	R.1993 d.321	25 N.J.R. 2860(a)
3:38-1.3, 4.1	Mortgage banker—mortgage banker non-servicing conversion; fees	25 N.J.R. 2625(b)		
3:18-3.2, 5.1, 5.3, 8.1	Secondary mortgage loans	25 N.J.R. 1033(b)	R.1993 d.218	25 N.J.R. 1965(a)
3:38-1.1, 1.10, 5.1	Mortgage banker non-servicing	25 N.J.R. 1035(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
3:41-2.1, 11	Cemetery Board: location of interment spaces and path access	25 N.J.R. 623(a)		

Most recent update to Title 3: TRANSMITTAL 1993-3 (supplement April 19, 1993)

CIVIL SERVICE—TITLE 4

Most recent update to Title 4: TRANSMITTAL 1992-1 (supplement September 21, 1992)

PERSONNEL—TITLE 4A

4A:1-5	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1314(c)		
4A:3	Classification, services and compensation	25 N.J.R. 1916(a)		
4A:4	Selection and appointment	25 N.J.R. 1085(b)	R.1993 d.270	25 N.J.R. 2509(a)

Most recent update to Title 4A: TRANSMITTAL 1993-3 (supplement April 19, 1993)

COMMUNITY AFFAIRS—TITLE 5

5:3	Department records	25 N.J.R. 2157(a)		
5:5	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA))	25 N.J.R. 1315(a)		
5:10	Maintenance of hotels and multiple dwellings	25 N.J.R. 2627(a)		
5:18-1.5, 2.4, 2.5, 2.7, 3.1–3.5, 3.7, 3.13, 3.17, 3.20, 3.30, App. 3A, 4.7, 4.9, 4.11, 4.12, 4.19	Uniform Fire Code	25 N.J.R. 393(a)	R.1993 d.197	25 N.J.R. 1868(a)
5:18-2.9, 2.12, 2.14, 2.16, 2.17	Uniform Fire Code: enforcement and penalties for violations	25 N.J.R. 397(a)	R.1993 d.195	25 N.J.R. 1872(a)
5:18-3.2, 3.3, 3.13, 3.19, App. 3A	Fire Prevention Code: junk yards, recycling centers, and other exterior storage sites	25 N.J.R. 1315(b)		
5:18-3.3	Uniform Fire Code: administrative correction regarding general precautions in rooming and boarding houses	———	———	25 N.J.R. 2519(a)
5:18-4.3, 4.7	Fire Safety Code: fire suppression systems in hospitals and nursing homes	25 N.J.R. 1316(a)		
5:18A-4.6	Fire Code enforcement: review of proposed action against certified fire official	25 N.J.R. 399(a)	R.1993 d.196	25 N.J.R. 1874(a)
5:18C-4.2, 5.2, 5.3, 5.4	Fire service training and certification	25 N.J.R. 1846(a)		
5:23-1.4, 2.16, 2.17	Uniform Construction Code: prior approvals; abandoned wells	25 N.J.R. 2158(a)		
5:23-1.6, 2.15, 4.18	Uniform Construction Code: prototype plan review	25 N.J.R. 1629(a)		
5:23-2.7, 9.3	Uniform Construction Code: ordinary repairs; interpretation	25 N.J.R. 2159(a)		
5:23-2.17, 8	Asbestos Hazard Abatement Subcode	24 N.J.R. 1422(a)	R.1993 d.198	25 N.J.R. 2519(b)
5:23-2.23	Uniform Construction Code: ventilation system requirements in Class I and II business and education buildings	25 N.J.R. 2161(a)		
5:23-3.4, 4.4, 4.18, 4.20, 5.3, 5.5, 5.19A, 5.21, 5.22, 5.23, 5.25	Uniform Construction Code: mechanical inspector license and mechanical inspections	25 N.J.R. 624(a)	R.1993 d.187	25 N.J.R. 1875(a)
5:23-4.4, 4.5, 4.5A, 4.12, 4.14, 4.18, 4.20	Uniform Construction Code: private on-site inspection agencies	25 N.J.R. 2162(a)		
5:23-8	Asbestos Hazard Abatement Subcode: administrative corrections	———	———	25 N.J.R. 2862(a)
5:25-2.5, 5.4	New home warranties and builders' registration: administrative corrections	———	———	25 N.J.R. 2545(a)
5:30	Local Finance Board rules	25 N.J.R. 1630(a)	R.1993 d.297	25 N.J.R. 2688(a)
5:51	Handicapped persons recreational opportunities	25 N.J.R. 2633(a)		
5:70-6.3	Congregate Housing Services Program: service subsidy formula	25 N.J.R. 2634(a)		
5:80-23	Housing and Mortgage Finance Agency: Housing Incentive Note Purchase Program	25 N.J.R. 1847(a)		
5:80-32	Housing and Mortgage Finance Agency: project cost certification	24 N.J.R. 2208(a)	Expired	
5:91-14	Council on Affordable Housing: interim procedures	25 N.J.R. 1118(a)		
5:92-1.1	Council on Affordable Housing: substantive rules	25 N.J.R. 1118(a)		
5:93	Council on Affordable Housing: substantive rules	25 N.J.R. 1118(a)		

Most recent update to Title 5: TRANSMITTAL 1993-4 (supplement April 19, 1993)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
MILITARY AND VETERANS' AFFAIRS—TITLE 5A				
5A:7-1	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1317(a)		
	Most recent update to Title 5A: TRANSMITTAL 1992-2 (supplement September 21, 1992)			
EDUCATION—TITLE 6				
6:3	School districts	25 N.J.R. 1095(a)	R.1993 d.272	25 N.J.R. 2249(a)
6:3-9	School Ethics Commission	25 N.J.R. 1924(a)		
6:9	Educational programs for pupils in State facilities	25 N.J.R. 400(a)	R.1993 d.194	25 N.J.R. 1889(b)
6:11-3.2	Professional licensure and standards: fees	25 N.J.R. 1111(a)	R.1993 d.266	25 N.J.R. 2263(a)
6:21-12	Use of school buses	25 N.J.R. 1095(a)	R.1993 d.272	25 N.J.R. 2249(a)
6:28-1.1, 1.3, 2.3, 2.6, 2.7, 3.2, 3.7, 4.1–4.4, 7.5, 8.4, 9.2, 10.1, 10.2, 11.2, 11.4, 11.9	Special education	25 N.J.R. 1318(a)		
6:28-8.1, 8.3, 8.4	Educational programs for pupils in State facilities	25 N.J.R. 400(a)	R.1993 d.194	25 N.J.R. 1889(b)
6:29-1.7, 9, 10	Eye protection in schools; reporting of child abuse allegations; safe and drug free schools	25 N.J.R. 1095(a)	R.1993 d.272	25 N.J.R. 2249(a)
6:30	Adult education programs	25 N.J.R. 1112(a)	R.1993 d.267	25 N.J.R. 2264(a)
	Most recent update to Title 6: TRANSMITTAL 1993-3 (supplement March 15, 1993)			
ENVIRONMENTAL PROTECTION AND ENERGY—TITLE 7				
7:0	Well construction and sealing: request for public comment regarding comprehensive rules	24 N.J.R. 3286(a)		
7:0	Green glass marketing and recycling: request for public input on feasibility study	25 N.J.R. 1654(a)		
7:0	Regulated Medical Waste Management Plan: public hearing and opportunity for comment	25 N.J.R. 1654(b)		
7:1D	Allocation of water supply costs for emergency water projects	25 N.J.R. 2635(a)		
7:1E	Discharges of petroleum and other hazardous substances: request for public comment on draft amendments	25 N.J.R. 2636(a)		
7:1F-2.2, App. A	Environmental Hazardous Substances and Industrial Survey lists: copper phthalocyanine compounds; confidentiality	25 N.J.R. 2166(a)		
7:1G-1–5, 7	Worker and Community Right to Know	25 N.J.R. 1631(a)		
7:1G-1.2, 6.1–6.11, 6.13-6.16	Worker and Community Right to Know Act: trade secrets and definitions	25 N.J.R. 858(a)		
7:1G-2.1, 6.4	Environmental Hazardous Substances and Industrial Survey lists: copper phthalocyanine compounds; confidentiality	25 N.J.R. 2166(a)		
7:1I	Processing of damage claims under Sanitary Landfill Facility Contingency Fund Act	25 N.J.R. 741(a)	R.1993 d.303	25 N.J.R. 2715(a)
7:1K-1.5, 3.1, 3.4, 3.9-3.11, 4.3, 4.5, 4.7, 5.1, 5.2, 6.1, 6.2, 7.2, 7.3, 9.2-9.5, 9.7, 12.6-12.9	Pollution Prevention Program requirements	25 N.J.R. 1849(a)		
7:1K-7.2	Priority industrial facilities and facility-wide permitting: administrative correction	———	———	25 N.J.R. 1876(a)
7:3	Bureau of Forestry rules	25 N.J.R. 1348(a)	R.1993 d.304	25 N.J.R. 2704(a)
7:4B	Historic Preservation Revolving Loan Program	25 N.J.R. 748(a)		
7:5A	Natural Areas System	25 N.J.R. 1350(a)		
7:5B	Open lands management	25 N.J.R. 1354(a)		
7:7A-1.4, 2.7	Freshwater Wetlands Protection Act rules: definition of project	25 N.J.R. 1642(a)		
7:7E-7.4	Coastal zone management: Outer Continental Shelf oil and gas exploration and development	25 N.J.R. 5(a)		
7:9-4	Surface water quality standards: request for public comment on draft Practical Quantitation Levels	24 N.J.R. 4008(a)		
7:9-4 (7:9B)	Surface water quality standards; draft Practical Quantitation Levels; total phosphorus limitations and criteria: extension of comment periods and notice of roundtable discussion	25 N.J.R. 404(a)		
7:9-4 (7:9B-1), 6.3	Surface water quality standards	24 N.J.R. 3983(a)		
7:9-4.5, 4.14, 4.15	Surface water quality standards	25 N.J.R. 405(a)		
7:9-4.14 (7:9B-1.14)	NJPDES program and surface water quality standards: request for public comment regarding total phosphorous limitations and criteria	24 N.J.R. 4008(b)		
7:9-4.14, 4.15 (7:9B-1.14, 1.15)	Surface water quality standards: administrative corrections to proposal	24 N.J.R. 4471(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
7:9A-1.1, 1.2, 1.6, 1.7, 2.1, 3.3, 3.4, 3.5, 3.7, 3.9, 3.10, 3.12, 3.14, 3.15, 5.8, 6.1, 8.2, 9.2, 9.3, 9.5, 9.6, 9.7, 10.2, 12.2–12.6, App. A, B	Individual subsurface sewage disposal systems	24 N.J.R. 1987(a)	R.1993 d.294	25 N.J.R. 2704(b)
7:11	New Jersey Water Supply Authority: policies and procedures	25 N.J.R. 1036(a)	R.1993 d.239	25 N.J.R. 2267(a)
7:11-2.2, 2.3, 2.9	Delaware and Raritan Canal-Spruce Run/Round Valley Reservoir System: rates for sale of water	24 N.J.R. 4472(a)	R.1993 d.240	25 N.J.R. 2267(b)
7:11-4.3, 4.4, 4.9	Manasquan Reservoir Water Supply System: rates for sale of water	24 N.J.R. 4474(a)	R.1993 d.241	25 N.J.R. 2269(a)
7:14-8.4	Request for adjudicatory hearing on penalty assessment for violations of Water Pollution Control Act: administrative correction	———	———	25 N.J.R. 2862(b)
7:14A	NJPDES Program: opportunity for interested party review of permitting system	25 N.J.R. 411(a)		
7:14A	NJPDES Program: extension of comment period for interested party review of permitting system	25 N.J.R. 1863(a)		
7:14A-1.8	NJPDES Program fees	25 N.J.R. 1358(a)		
7:14A-1.9, 3.14	Surface water quality standards	24 N.J.R. 3983(a)		
7:14A-4.7	Handling of substances displaying the Toxicity Characteristic	25 N.J.R. 753(a)	R.1993 d.300	25 N.J.R. 2718(a)
7:14B-1.6, 2.2, 2.6, 2.7, 2.8, 3.1–3.8	Underground Storage Tanks Program fees	25 N.J.R. 1363(a)		
7:22-3.4, 3.7, 3.8, 3.9, 3.11, 3.17, 3.20, 3.26, 3.27, 3.32, 3.34, 3.37, 4.4, 4.7, 4.8, 4.9, 4.11, 4.13, 4.17, 4.20, 4.26, 4.29, 4.32, 4.34, 4.37, 4.46, 5.4, 5.11, 5.12, 6.17, 6.27, 10.2, 10.3, 10.8, 10.9, 10.11, 10.12	Financial assistance programs for wastewater treatment facilities	24 N.J.R. 4310(b)	R.1993 d.242	25 N.J.R. 2271(a)
7:22-9.1, 9.2, 9.4, 9.11–9.15, 10.1, 10.2, 10.4, 10.5, 10.6	Sewage Infrastructure Improvement Act grants: interconnection and cross-connection abatement	25 N.J.R. 1643(a)		
7:22A-1.4, 1.5, 1.7, 1.12, 1.15, 1.16, 2.4, 2.5, 2.6, 2.8, 3.4, 4.2, 4.5, 4.8, 4.11, 6.1–6.9, 6.11, 6.12, 6.14, 6.15, 7	Sewage Infrastructure Improvement Act grants: interconnection and cross-connection abatement	25 N.J.R. 1643(a)		
7:25-1.5	Fish and Game Council: license, permit and stamp fees	25 N.J.R. 1928(a)		
7:25-5	1993-94 Game Code	25 N.J.R. 1930(a)		
7:25-5.13	1992-93 Game Code: administrative correction regarding migratory birds	———	———	25 N.J.R. 2001(c)
7:25-7.13, 14.1, 14.2, 14.4, 14.6, 14.7, 14.8, 14.11, 14.12, 14.13	Crab management	25 N.J.R. 1371(a)		
7:25-11	Introduction of imported or non-native shellfish or finfish into State's marine waters	24 N.J.R. 3660(a)		
7:25-18.1, 18.14	Summer flounder permit conditions	25 N.J.R. 2167(a)		
7:25-18.12	Weakfish management: administrative changes	———	———	25 N.J.R. 2001(d)
7:25-18.12	Weakfish management: administrative correction	———	———	25 N.J.R. 2281(a)
7:25-18.16	Taking of horseshoe crabs	24 N.J.R. 2978(a)	R.1993 d.185	25 N.J.R. 1876(b)
7:25A-1.2, 1.4, 1.9, 4.3	Oyster management	25 N.J.R. 754(a)		
7:26-1.4, 9.3	Hazardous waste management: satellite accumulation areas	25 N.J.R. 1864(a)		
7:26-2.11, 2.13, 2B.9, 2B.10, 6.2, 6.8	Solid waste flow through transfer stations and materials recovery facilities	24 N.J.R. 3286(c)		
7:26-4A.6	Hazardous waste program fees: annual adjustment	24 N.J.R. 2001(a)	R.1993 d.302	25 N.J.R. 2719(a)
7:26-6.6	Procedure for modification of waste flows	25 N.J.R. 991(a)		
7:26-8.8, 8.12, 8.19	Handling of substances displaying the Toxicity Characteristic	25 N.J.R. 753(a)		
7:26-8.13, 8.16, 8.19	Hazardous waste listings: F024 and F025	25 N.J.R. 755(a)		
7:26-8.20	Used motor oil recycling	24 N.J.R. 2383(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
7:26-12.3	Hazardous waste management: interim status facilities	24 N.J.R. 4253(a)		
7:26A-6	Used motor oil recycling	24 N.J.R. 2383(a)	R.1993 d.342	25 N.J.R. 2863(a)
7:26B-1.3, 1.10, 1.11, 1.12	Environmental Cleanup Responsibility Act Program fees	25 N.J.R. 1375(a)		
7:26B-7, 9.3	Remediation of contaminated sites: Department oversight	24 N.J.R. 1281(b)	R.1993 d.186	25 N.J.R. 2002(a)
7:26C	Remediation of contaminated sites: Department oversight	24 N.J.R. 1281(b)	R.1993 d.186	25 N.J.R. 2002(a)
7:26E	Technical requirements for contaminated site remediation	24 N.J.R. 1695(a)	R.1993 d.245	25 N.J.R. 2281(b)
7:27-8.1, 8.3, 8.27	Air pollution control: requirements and exemptions under facility-wide permits	24 N.J.R. 4323(a)		
7:27-19	Control and prohibition of air pollution from oxides of nitrogen	25 N.J.R. 631(a)		
7:27-25.9	Oxygenated fuels program: variance for contemporaneous averaging provision	———	———	25 N.J.R. 2720(a)
7:27-26	Low Emissions Vehicle Program	25 N.J.R. 1381(a)		
7:27A-3.5, 3.10	Control and prohibition of air pollution from oxides of nitrogen: civil administrative penalties	25 N.J.R. 631(a)		
7:28-15, 16.2, 16.8	Medical diagnostic x-ray installations; dental radiographic installations	25 N.J.R. 7(a)		
7:28-15, 16.2, 16.8	Medical diagnostic x-ray installations; dental radiographic installations; extension of comment period	25 N.J.R. 1039(a)		
7:29-1.1, 1.2, 2	Determination of noise from stationary sources: extension of comment period	25 N.J.R. 1425(a)		
7:29-1.1, 1.5, 2	Determination of noise from stationary sources	25 N.J.R. 1040(a)	R.1993 d.301	25 N.J.R. 2721(a)
7:31	Toxic Catastrophe Prevention Act Program	25 N.J.R. 1425(b)		
7:32	Energy conservation in State buildings	25 N.J.R. 1655(a)	R.1993 d.347	25 N.J.R. 2868(a)
7:36	Green Acres Program: opportunity to review draft rule revisions	25 N.J.R. 1473(a)		
7:36-9	Green Acres Program: nonprofit land acquisition	24 N.J.R. 2405(a)	R.1993 d.265	25 N.J.R. 2472(a)
7:50-4.1, 4.70	Pinelands Comprehensive Management Plan: expiration of development approvals and waivers	25 N.J.R. 225(a)	R.1993 d.211	25 N.J.R. 2119(a)
7:61	Commissioners of Pilotage: licensure of Sandy Hook pilots	24 N.J.R. 3477(a)		
7:61-3	Board of Commissioners of Pilotage: Drug Free Workplace Program	25 N.J.R. 625(a)	R.1993 d.212	25 N.J.R. 2123(a)

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8:2	Creation of birth record	24 N.J.R. 4325(a)		
8:2	Creation of birth record: reopening of comment period	25 N.J.R. 660(a)		
8:18	Catastrophic Illness in Children Relief Fund Program	25 N.J.R. 2169(a)		
8:21-3.13	Repeal (see 8:21-3A)	24 N.J.R. 3100(a)		
8:21-3A	Registration of manufacturers and wholesale distributors of non-prescription drugs, and manufacturers and wholesale distributors of devices	24 N.J.R. 3100(a)		
8:24	Packing of refrigerated foods in reduced oxygen packages by retail establishments: preproposal	25 N.J.R. 660(b)		
8:24	Retail food establishments and food and beverage vending machines	25 N.J.R. 662(a)	R.1993 d.201	25 N.J.R. 1965(b)
8:24-8, 9	Temporary and mobile retail food establishments and agricultural markets	25 N.J.R. 1965(b)	R.1993 d.345	25 N.J.R. 2872(a)
8:25	Youth Camp Safety Act standards	25 N.J.R. 756(a)	R.1993 d.264	25 N.J.R. 2546(b)
8:31B-2, 3.70	Hospital reimbursement: bill-patient data submissions; revenue cap monitoring	25 N.J.R. 1660(a)		
8:33	Certificate of Need: application and review process	25 N.J.R. 2171(a)		
8:33-3.11	Certificate of Need process for demonstration and research projects	24 N.J.R. 3104(a)		
8:33A-1.2, 1.16	Hospital Policy Manual: applicant preference; equity requirement	24 N.J.R. 4476(a)		
8:33S	Surgical facilities: certificate of need	25 N.J.R. 2790(a)		
8:35A-1.2, 3.4, 3.6, 4.1, 5.3	Maternal and child health consortia: fiscal management and staffing	25 N.J.R. 1116(a)	R.1993 d.285	25 N.J.R. 2546(c)
8:39	Long-term care facilities: licensing standards	25 N.J.R. 1474(a)	R.1993 d.341	25 N.J.R. 2878(a)
8:39-13.4, 27.1, 27.8, 29.4, 33.2, 45, 46	Long-term care facilities: use of restraints and psychoactive drugs; pharmacy supplies; Alzheimer's and dementia care services	24 N.J.R. 4228(a)	R.1993 d.230	25 N.J.R. 2548(a)
8:40-1.1, 2.3, 2.7, 3.1, 4.12, 5.23, 6.26	Invalid coach and ambulance services: licensure; street EMS	25 N.J.R. 2663(a)		
8:41	Mobile intensive care programs	24 N.J.R. 3255(b)	R.1993 d.202	25 N.J.R. 2721(b)
8:41-4.1, 10.5-10.13, 11	Mobile intensive care programs: standing orders; paramedic clinical training objectives	25 N.J.R. 2665(a)		
8:42B	Drug treatment facilities: standards for licensure	25 N.J.R. 1476(a)	R.1993 d.340	25 N.J.R. 2879(a)

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8:43	Licensure of residential health care facilities	25 N.J.R. 25(a)		
8:43	Licensure of residential health care facilities: public hearing	25 N.J.R. 757(a)		
8:43A	Ambulatory care facilities: public meeting and request for comments regarding Manual of Standards for Licensure	24 N.J.R. 3603(a)		
8:43A	Licensure of ambulatory care facilities	25 N.J.R. 757(b)		
8:43G-5.10	Acute care hospital participation in New Jersey Poison Control Information and Education System	25 N.J.R. 792(a)	R.1993 d.229	25 N.J.R. 1969(a)
8:43G-5.10	Hospital payments to maternal and child health consortia	25 N.J.R. 1295(a)	R.1993 d.236	25 N.J.R. 2555(a)
8:43G-5.10, 19.1, 19.20	Hospital licensing standards: funding for regionalized services; obstetric services structural organization	25 N.J.R. 1117(a)	R.1993 d.286	25 N.J.R. 2554(a)
8:44-2.1, 2.14	Clinical laboratory licensure: HIV testing	25 N.J.R. 2184(a)		
8:44-2.2, 3	Limited purpose laboratories	25 N.J.R. 668(a)	R.1993 d.200	25 N.J.R. 1969(b)
8:57-3.2	Physician reporting of occupational and environmental diseases and injuries	25 N.J.R. 2186(a)		
8:59-1, 2, 5, 6, 9, 11, 12	Worker and Community Right to Know Act rules	25 N.J.R. 864(a)		
8:59-3.1, 3.2, 3.3, 3.5-3.9, 3.11, 3.13-3.17	Worker and Community Right to Know Act: trade secrets and definitions	25 N.J.R. 858(a)		
8:59-App. A, B	Worker and Community Right to Know Act: preproposal concerning Hazardous Substance List and Special Health Hazard Substance List	25 N.J.R. 792(a)		
8:70	List of Interchangeable Drug Products: evaluation and acceptance criteria	25 N.J.R. 1814(a)	R.1993 d.333	25 N.J.R. 2879(b)
8:71	Interchangeable drug products (see 24 N.J.R. 2557(b), 3173(a), 4260(b); 25 N.J.R. 582(a))	24 N.J.R. 1674(a)	R.1993 d.226	25 N.J.R. 1970(b)
8:71	Interchangeable drug products (see 24 N.J.R. 3174(c), 3728(a), 4262(a); 25 N.J.R. 583(a))	24 N.J.R. 2414(b)	R.1993 d.338	25 N.J.R. 2882(b)
8:71	Interchangeable drug products (see 24 N.J.R. 4261(a); 25 N.J.R. 582(b))	24 N.J.R. 2997(a)	R.1993 d.225	25 N.J.R. 1970(a)
8:71	Interchangeable drug products (see 25 N.J.R. 580(b))	24 N.J.R. 4009(a)	R.1993 d.339	25 N.J.R. 2883(a)
8:71	Interchangeable drug products (see 25 N.J.R. 1221(a), 1969(c))	25 N.J.R. 55(a)	R.1993 d.337	25 N.J.R. 2882(a)
8:71	Interchangeable drug products (see 25 N.J.R. 1970(c))	25 N.J.R. 875(a)	R.1993 d.336	25 N.J.R. 2881(b)
8:71	Interchangeable drug products	25 N.J.R. 1814(b)	R.1993 d.335	25 N.J.R. 2881(a)
8:71	Interchangeable drug products	25 N.J.R. 1815(a)	R.1993 d.334	25 N.J.R. 2879(c)
8:100	State Health Planning Board: public hearings on draft chapters of State Health Plan	24 N.J.R. 3788(a)		
8:100	State Health Plan: draft chapters	24 N.J.R. 3789(a)		
8:100	State Health Plan: draft chapters on AIDS, and preventive and primary care	24 N.J.R. 4151(a)		

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9:1-5.11	Regional accreditation of degree-granting proprietary institutions	24 N.J.R. 3207(a)		
9:2-11	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1323(a)		
9:4-1.12	County college construction projects	25 N.J.R. 668(b)	R.1993 d.224	25 N.J.R. 1971(a)
9:7-2.6	Student assistance programs: independent student status	25 N.J.R. 1945(a)		
9:9	NJHEAA student loan programs	25 N.J.R. 2187(a)		
9:11-1.1, 1.2, 1.4, 1.6, 1.10, 1.22, 1.23	Educational Opportunity Fund: student eligibility for undergraduate grants	25 N.J.R. 1663(a)		
9:11-1.5	Educational Opportunity Fund Program: financial eligibility for undergraduate grants	25 N.J.R. 1946(a)		

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10:1-2	Public comments and petitions regarding Department rules (recodify as 10:1A)	25 N.J.R. 1042(a)	R.1993 d.271	25 N.J.R. 2557(a)
10:4	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1323(b)		
10:8	Patient advance directives; DNR orders; declaration of death	25 N.J.R. 2669(a)		
10:14	Statewide Respite Care Program Manual	25 N.J.R. 876(a)	R.1993 d.256	25 N.J.R. 2557(b)
10:15-1.2	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
10:15A-1.2	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
10:15B-1.2, 2.1	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		

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10:15C-1.1	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
10:31-1.4, 2.1, 2.2, 2.3, 8.1, 9.1	Screening and Screening Outreach Programs: mental health services	25 N.J.R. 1324(a)		
10:37-5.37–5.43	Repeal (see 10:37A)	25 N.J.R. 2672(a)		
10:37-5.46–5.50, 12	Community mental health services: children's partial care programs	25 N.J.R. 669(a)		
10:37-6.62–6.72, 6.92–6.98, 9, 10	Community mental health programs: quality assurance standards, site review and certification	25 N.J.R. 2193(a)		
10:37A	Community residences for mentally ill adults	25 N.J.R. 2672(a)		
10:37B	Psychiatric community residences for youth	25 N.J.R. 2197(a)		
10:38A	Pre-Placement Program for patients at State psychiatric facilities	24 N.J.R. 4326(a)		
10:39	Repeal (see 10:37A)	25 N.J.R. 2672(a)		
10:41-2.3, 2.8, 2.9	Division of Developmental Disabilities: access to client records and record confidentiality	25 N.J.R. 432(a)		
10:51	Pharmaceutical Services Manual	24 N.J.R. 3053(a)		
10:52-1.1	Hospital services reimbursement methodology	25 N.J.R. 1582(a)	R.1993 d.263	25 N.J.R. 2560(a)
10:52-1.9, 1.13	Reimbursement methodology for distinct units in acute care hospitals and for private psychiatric hospitals	24 N.J.R. 4477(a)		
10:52-1.23	Inpatient hospital services: adjustments to Medicaid payer factors	24 N.J.R. 4478(a)		
10:52-5, 6, 7, 8, 9	Hospital services reimbursement methodology	25 N.J.R. 1582(a)	R.1993 d.263	25 N.J.R. 2560(a)
10:53-1.1	Reimbursement methodology for special hospitals	24 N.J.R. 4477(a)		
10:63-3.3, 3.8	Long-term care services: elimination of salary regions	25 N.J.R 433(a)		
10:66-1.2, 1.6, 1.7	Independent clinic services: ambulatory care/family planning/surgical facility	25 N.J.R. 2683(a)		
10:69	Hearing Aid Assistance to the Aged and Disabled Eligibility Manual	25 N.J.R. 228(a)	R.1993 d.281	25 N.J.R. 2589(a)
10:69-5.8; 69A-5.4, 5.6, 6.12, 7.2; 69B-4.13	HAAAD, PAAD, and Lifeline programs: fair hearing requests, prescription reimbursement, benefits recovery	24 N.J.R. 4329(a)		
10:71-4.8, 5.4, 5.5, 5.6, 5.9	Medicaid Only: eligibility computation amounts	25 N.J.R. 1818(a)		
10:72-1.1, 4.1, 4.5	New Jersey Care—Special Medicaid Manual: specified low-income Medicare beneficiaries	25 N.J.R. 1042(b)		
10:81-11.4, 11.16A, 11.20	Public Assistance Manual: closing criteria for IV-D cases; application fee for non-AFDC applicants	25 N.J.R. 881(a)		
10:81-11.5, 11.7, 11.9, 11.20, 11.21	Public Assistance Manual: child support and paternity services	24 N.J.R. 2328(a)	R.1993 d.282	25 N.J.R. 2589(b)
10:81-14.18A	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
10:82-5.3	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
10:84	Administration of public assistance programs: agency action on public hearing	24 N.J.R. 4480(a)		
10:84-1	Administration of public assistance programs	24 N.J.R. 4480(b)		
10:85-1.1, 3.1, 3.2, 4.2, 7.2	Eligibility for employable GA recipients	25 N.J.R. 1714(a)		
10:86-10.2, 10.6	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
10:121A-1.5, 2.7	Manual of Requirements for Adoption Agencies: administrative correction and changes	————	————	25 N.J.R. 2591(a)
10:121A-1.5, 3.4, 5.4, 5.5, 5.6, 5.18, 5.10	Manual of Requirements for Adoption Agencies: administrative corrections	————	————	25 N.J.R. 2883(b)
10:123-3.4	Personal needs allowance for eligible residents of residential health care facilities and boarding houses	25 N.J.R. 2684(a)		
10:127	Residential child care facilities: manual of requirements	25 N.J.R. 1716(a)		
10:133C-4	Division of Youth and Family Services: case goals	25 N.J.R. 1947(a)		
10:133D-2	DYFS case management: case plan	25 N.J.R. 2209(a)		
10:133D-4	DYFS case management: in-person visits with clients and substitute care providers	25 N.J.R. 2210(a)		
10:140	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1326(a)		

Most recent update to Title 10: TRANSMITTAL 1993-4 (supplement April 19, 1993)

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10A:1-2.2	"Division of Operations", "indigent inmate" defined	25 N.J.R. 1043(a)	R.1993 d.246	25 N.J.R. 2591(b)
10A:1-3	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1326(b)		
10A:3-3.7	Use of chemical agents	25 N.J.R. 1044(a)	R.1993 d.219	25 N.J.R. 1971(b)
10A:31-5.1, 5.2, 5.3	Adult county correctional facilities: staff training	25 N.J.R. 1817(a)	R.1993 d.324	25 N.J.R. 2884(a)
10A:71-3.2, 3.21	State Parole Board: calculation of parole eligibility terms	25 N.J.R. 1665(a)		
10A:71-3.47	Inmate parole hearings: victim testimony process	24 N.J.R. 4483(a)		
10A:71-6.4, 7.3	State Parole Board: conditions of parole	25 N.J.R. 435(a)		

Most recent update to Title 10A: TRANSMITTAL 1992-7 (supplement December 21, 1992)

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11:1-3	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1327(a)		
11:1-7	New Jersey Property-Liability Insurance Guaranty Association: plan of operation	25 N.J.R. 1045(a)		
11:1-31	Surplus lines insurer eligibility	25 N.J.R. 1819(a)		
11:1-32.4	Automobile insurance: limited assignment distribution servicing carriers	24 N.J.R. 519(a)	R.1992 d.371	24 N.J.R. 3414(a)
11:1-32.4	Workers' compensation self-insurance: extension of comment period	24 N.J.R. 2708(b)		
11:1-34	Surplus lines: exportable list procedures	24 N.J.R. 4331(a)		
11:2-33.3, 33.4	Workers' compensation self-insurance: administrative corrections	———	———	25 N.J.R. 1877(a)
11:2-34	Surplus lines: allocation of premium tax and surcharge	25 N.J.R. 1827(a)		
11:3-2.2, 2.4, 2.5, 2.6, 2.11, 2.12	Personal Automobile Insurance Plan	25 N.J.R. 2212(a)		
11:3-2.8, 33.2, 34.4, 44	Automobile insurance: provision of coverage to all applicants who qualify as eligible persons	25 N.J.R. 1290(a)	R.1993 d.238	25 N.J.R. 2479(a)
11:3-3	Limited assignment distribution servicing carriers	25 N.J.R. 1327(b)		
11:3-16.7	Automobile insurance: rating programs for physical damage coverages	24 N.J.R. 3604(a)		
11:3-19.3, 34.3	Automobile insurance eligibility rating plans: incorporation of merit rating surcharge	24 N.J.R. 2332(a)		
11:3-20.5, 20A.1	Automobile insurers: reporting apportioned share of MTF losses in excess profits reports; ratio limiting the effect of negative excess investment income	25 N.J.R. 1829(a)		
11:3-28.1, 28.2, 28.4, 28.6, 28.10-28.13, App. A, B	Reimbursement of excess medical expense benefits paid by automobile insurers	25 N.J.R. 2636(b)		
11:3-29.2, 29.4, 29.6	Automobile insurance PIP coverage: medical fee schedules	25 N.J.R. 229(b)		
11:3-29.6	Automobile PIP coverage: physical therapy services	24 N.J.R. 2998(a)		
11:3-33.2	Appeals from denial of automobile insurance: failure to act timely on written application for coverage	24 N.J.R. 2128(b)	Expired	
11:3-35.5	Automobile insurance rating: eligibility points of principal driver	24 N.J.R. 2331(a)		
11:3-42.2, 42.9	Producer Assignment Program: request for exemption	25 N.J.R. 2215(a)		
11:5-1.9	Real Estate Commission: transmittal of funds to lenders	24 N.J.R. 4268(a)		
11:5-1.23	Real Estate Commission: transmittal by licensees of written offers on property	24 N.J.R. 3486(a)		
11:5-1.38	Real Estate Commission: pre-proposal regarding buyer-brokers	24 N.J.R. 3488(b)		
11:5-1.43	Real Estate Commission: licensee provision of Agency Information Statement	25 N.J.R. 1948(a)		
11:5-1.43	Real Estate Commission: extension of comment period regarding licensee provision of Agency Information Statement	25 N.J.R. 2645(a)		
11:6-2	Workers' compensation managed care organizations	25 N.J.R. 1330(a)	R.1993 d.346	25 N.J.R. 2885(a)
11:13-7.4, 7.5	Commercial lines: exclusions from coverage; refiling policy forms	25 N.J.R. 1053(a)		
11:13-8	Commercial lines: prospective loss costs filing procedures	25 N.J.R. 1047(a)		
11:15-3	Joint insurance funds for local government units providing group health and term life benefits	25 N.J.R. 436(a)		
11:17	Producer licensing	25 N.J.R. 883(a)	R.1993 d.206	25 N.J.R. 1972(a)
11:17-1.2, 2.3–2.15, 5.1–5.6	Insurance producer licensing	24 N.J.R. 3216(a)		
11:17A-1.2, 1.3, 1.4, 1.5, 4.6	Insurance producers and limited insurance representatives: licensure and registration	25 N.J.R. 446(a)	R.1993 d.199	25 N.J.R. 1878(a)
11:17A-1.2, 1.7	Appeals from denial of automobile insurance: failure to act timely on written application for coverage; premium quotation	24 N.J.R. 2128(b)	Expired	
11:17A-1.2, 1.7	Automobile insurance: provision of coverage to all applicants who qualify as eligible persons	25 N.J.R. 1290(a)	R.1993 d.238	25 N.J.R. 2479(a)
11:19-3	Financial Examination Monitoring System: data submission by surplus lines producers and insurers	24 N.J.R. 3003(a)	R.1993 d.232	25 N.J.R. 1972(b)
11:20	Individual Health Coverage Program	Emergency (expires 8-13-93)	R.1993 d.344	25 N.J.R. 2945(a)

Most recent update to Title 11: TRANSMITTAL 1993-4 (supplement April 19, 1993)

LABOR—TITLE 12				
12:7	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1334(a)		

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12:7	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA): extension of comment period	25 N.J.R. 2216(a)		
12:18-1.1, 2.4, 2.27, 2.40, 2.43, 2.48, 3.1, 3.2, 3.3	Temporary Disability Benefits Program	25 N.J.R. 1515(c)		
12:23	Workforce Development Partnership Program: application and review process for customized training services	25 N.J.R. 449(a)		
12:23-3	Workforce Development Partnership Program: application and review process for individual training grants	25 N.J.R. 884(a)		
12:23-4	Workforce Development Partnership Program: application and review process for approved training	25 N.J.R. 886(a)		
12:23-5	Workforce Development Partnership Program: application and review process for additional unemployment benefits during training	25 N.J.R. 887(a)		
12:23-6	Workforce Development Partnership Program: application and review process for employment and training grants for services to disadvantaged workers	25 N.J.R. 1054(a)		
12:45	Vocational Rehabilitation Services: waiver of sunset provision of Executive Order No. 66(1978)	25 N.J.R. 2216(b)		
12:58-1.2	Child labor: student learner in cooperative vocational education program	25 N.J.R. 889(a)	R.1993 d.183	25 N.J.R. 1881(a)
12:60-3.2, 4.2	Prevailing wages on public works contracts: telecommunications worker	24 N.J.R. 2689(a)		
12:60-3.2, 4.2	Prevailing wages on public works contracts: extension of comment period	24 N.J.R. 3015(b)		
12:60-3.2, 4.2	Prevailing wages for public works: extension of comment period	24 N.J.R. 3607(a)		
12:100-4.1, 4.2	Public employee safety and health: Process Safety Management of Highly Hazardous Chemicals; employer defined	25 N.J.R. 890(a)	R.1993 d.184	25 N.J.R. 1882(a)
12:100-4.2	Public employee safety and health: occupational exposure to bloodborne pathogens	24 N.J.R. 3607(b)	R.1993 d.323	25 N.J.R. 2894(a)
12:100-4.2	Public employee safety and health: exposure to hazardous chemicals in laboratories	25 N.J.R. 453(b)	R.1993 d.308	25 N.J.R. 2688(b)
12:195	Carnival-amusement rides safety	25 N.J.R. 1832(a)	R.1993 d.343	25 N.J.R. 2896(a)
12:195-2.1, 3.22, 6.1, 7	Carnival and amusement rides: bungee jumping	Emergency (expires 7-2-93)	R.1993 d.244	25 N.J.R. 2128(a)

Most recent update to Title 12: TRANSMITTAL 1993-3 (supplement April 19, 1993)

COMMERCE AND ECONOMIC DEVELOPMENT—TITLE 12A

12A:1	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1335(b)		
12A:9	Development of small businesses and women and minority businesses: waiver of sunset provision of Executive Order No. 66(1978)	25 N.J.R. 1335(c)		
12A:9	Development of small businesses and women and minority businesses	25 N.J.R. 1752(a)	R.1993 d.309	25 N.J.R. 2689(a)
12A:11	Certification of women-owned and minority-owned businesses	25 N.J.R. 1056(a)	R.1993 d.237	25 N.J.R. 2484(a)
12A:11-1.2, 1.3, 1.4, 1.7	Certification of women-owned and minority-owned businesses: extension of comment period	25 N.J.R. 2216(c)		
12A:11-1.2, 1.3, 1.4, 1.7	Certification of women-owned and minority-owned businesses	25 N.J.R. 2484(a)		
12A:31-1.4	New Jersey Development Authority: interest rate on direct loans	25 N.J.R. 891(a)	R.1993 d.243	25 N.J.R. 2484(b)
12A:120	Urban Enterprise Zone Program and business certification	25 N.J.R. 2645(b)		

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LAW AND PUBLIC SAFETY—TITLE 13

13:1	Police Training Commission rules	25 N.J.R. 1336(a)	R.1993 d.325	25 N.J.R. 2897(a)
13:1C	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1338(a)		
13:2-14.2, 14.7, 20.6, 21.4	Alcoholic beverage control: permits, insignia, and fees	25 N.J.R. 1340(a)	R.1993 d.288	25 N.J.R. 2485(a)
13:3	Amusement games control	25 N.J.R. 891(b)	R.1993 d.233	25 N.J.R. 1987(a)
13:3	Amusement games control: effective date of readopted rules	———	———	25 N.J.R. 2689(b)
13:19-10.1	Operating motorcycle or motorized bicycle without protective helmet	25 N.J.R. 2646(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
13:19-1.1, 1.7	Driver Control Service: administrative hearings applicability	25 N.J.R. 893(a)		
13:20-37	Motor vehicles with modified chassis height	24 N.J.R. 3662(a)		
13:20-37	Motor vehicles with modified chassis height: extension of comment period	24 N.J.R. 4333(b)		
13:20-38	Dimensional standards for automobile transporters	25 N.J.R. 1342(a)		
13:26	Transportation of bulk commodities	25 N.J.R. 1343(a)		
13:28	Board of Cosmetology and Hairstyling rules	25 N.J.R. 893(b)	R.1993 d.287	25 N.J.R. 2485(b)
13:29-1.13	Board of Accountancy: biennial renewal fee for inactive or retired licensees	25 N.J.R. 1665(b)		
13:30-1.1	Board of Dentistry: qualifications of applicants for licensure to practice	25 N.J.R. 2216(d)		
13:30-8.5	Board of Dentistry: complaint review procedures	24 N.J.R. 2800(a)		
13:30-8.6	Board of Dentistry: professional advertising	24 N.J.R. 2801(a)	R.1993 d.332	25 N.J.R. 2898(a)
13:30-8.7	Board of Dentistry: patient records	25 N.J.R. 1833(a)		
13:30-8.18	Continuing dental education	25 N.J.R. 1344(a)		
13:33-1.35, 1.36	Ophthalmic dispensers and technicians: referrals; space rental agreements	24 N.JR. 4010(a)		
13:35-6.13, 9	Acupuncture Examining Board: practice of acupuncture	24 N.J.R. 4013(a)	R.1993 d.299	25 N.J.R. 2689(c)
13:35-6.13, 10.9	Board of Medical Examiners: fee schedule; athletic trainer registration fee	25 N.J.R. 1058(a)	R.1993 d.260	25 N.J.R. 2487(a)
13:35-6.18	Board of Medical Examiners: control of anabolic steroids	24 N.J.R. 4012(a)		
13:35-10	Practice of athletic trainers	25 N.J.R. 265(a)		
13:37	Board of Nursing rules	25 N.J.R. 455(b)		
13:37-12.1, 14	Board of Nursing: certification of homemaker-home health aides	25 N.J.R. 1950(a)		
13:37-13.1, 13.2	Nurse anesthetist: conditions for practice	24 N.J.R. 4020(a)	R.1993 d.306	25 N.J.R. 2695(a)
13:38-1.2, 1.3, 2.5	Practice of optometry: permissible advertising	24 N.J.R. 4237(a)		
13:39-1.3	Board of Pharmacy: fee schedule	25 N.J.R. 1666(a)		
13:39-5.2	Board of Pharmacy: information on prescription labels	25 N.J.R. 1667(a)		
13:39-7.14	Board of Pharmacy: patient profile record system and patient counseling by pharmacist	25 N.J.R. 266(a)	R.1993 d.307	25 N.J.R. 2697(a)
13:41-2.1	Board of Professional Planners: professional misconduct	24 N.J.R. 3221(a)		
13:44C	Audio and Speech-Language Pathology Advisory Committee rules	25 N.J.R. 1668(a)		
13:45A-24	Toy and bicycle safety	24 N.J.R. 3019(b)		
13:45A-24	Toy and bicycle safety: extension of comment period	24 N.J.R. 3666(a)		
13:46-23.5, 23A	State Athletic Control Board: standards of ethical conduct	24 N.J.R. 4489(a)		
13:70-3.40	Thoroughbred racing: minimum age for admittance to racetrack	25 N.J.R. 2647(a)		
13:70-12.4	Thoroughbred racing: claimed horse	25 N.J.R. 1059(a)		
13:70-14A.8	Thoroughbred racing: possession of drugs or drug instruments	25 N.J.R. 1060(a)	R.1993 d.262	25 N.J.R. 2488(a)
13:70-29.50	Thoroughbred racing: daily triple payoff in dead heat for win	25 N.J.R. 1671(a)		
13:71-2.3	Harness racing: suspension from driving	25 N.J.R. 2647(b)		
13:71-5.18	Harness racing: minimum age for admittance to racetrack	25 N.J.R. 2648(a)		
13:71-23.9	Harness racing: possession of drugs or drug instruments	25 N.J.R. 1061(a)	R.1993 d.261	25 N.J.R. 2488(b)
13:75-1.7	Violent Crimes Compensation Board: reimbursement for funeral expenses	25 N.J.R. 674(a)	R.1993 d.250	25 N.J.R. 2488(c)
13:75-1.12	Violent Crimes Compensation Board: attorney's fees requiring affidavit of service	25 N.J.R. 674(b)	R.1993 d.251	25 N.J.R. 2489(a)
13:76	Arson investigators: training and certification	25 N.J.R. 896(a)	R.1993 d.208	25 N.J.R. 1987(b)
13:81-1.2, 2.1	Statewide 9-1-1 emergency telecommunications system	24 N.J.R. 4493(a)	R.1993 d.209	25 N.J.R. 1987(c)

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PUBLIC UTILITIES (BOARD OF REGULATORY COMMISSIONERS)—TITLE 14

14:3-3.6	Discontinuance of service to multi-family dwellings	25 N.J.R. 1346(a)		
14:3-5.1	Relocation or closing of utility office	24 N.J.R. 2132(a)	R.1993 d.298	25 N.J.R. 2699(a)
14:3-6.5	Public records	24 N.J.R. 1966(a)	R.1993 d.273	25 N.J.R. 2489(b)
14:3-7.15	Discontinuance of services to customers: notification of municipalities and others	24 N.J.R. 3023(a)		
14:3-10.15	Solid waste collection: customer lists	24 N.J.R. 3286(c)		
14:6-5	Natural gas service: inspection and operation of master meter systems	24 N.J.R. 4494(a)	R.1993 d.247	25 N.J.R. 2490(a)
14:10-5	Competitive telecommunications services	24 N.J.R. 1868(a)	R.1993 d.248	25 N.J.R. 2492(a)
14:10-7	Telephone access to adult-oriented information	24 N.J.R. 1238(a)	R.1993 d.180	25 N.J.R. 1882(b)
14:11-7.10	Solid waste disposal facilities: initial tariff for special in lieu payment	24 N.J.R. 3286(c)		
14:11-8	Natural gas pipelines	25 N.J.R. 897(a)		

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14:18-2.11	Cable television: pre-proposal regarding disposition of on-premises wiring	24 N.J.R. 4496(a)		
14:18-2.11	Cable television: change in hearing date and comment period for pre-proposal regarding disposition of on-premises wiring	25 N.J.R. 270(a)		
14:18-9.2, 10.1–10.5	Cable television: testing of service and technical standards for system operation	24 N.J.R. 4497(a)	R.1993 d.234	25 N.J.R. 2700(a)
	Most recent update to Title 14: TRANSMITTAL 1993-3 (supplement March 15, 1993)			
ENERGY—TITLE 14A				
	Most recent update to Title 14A: TRANSMITTAL 1993-1 (supplement February 16, 1993)			
STATE—TITLE 15				
15:1	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1347(a)		
15:2	Commercial recording filing and expedited service	25 N.J.R. 901(a)	R.1993 d.193	25 N.J.R. 1884(a)
	Most recent update to Title 15: TRANSMITTAL 1993-1 (supplement January 19, 1993)			
PUBLIC ADVOCATE—TITLE 15A				
	Most recent update to Title 15A: TRANSMITTAL 1990-3 (supplement August 20, 1990)			
TRANSPORTATION—TITLE 16				
16:1B	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1478(a)		
16:25	Utility accommodation	25 N.J.R. 2217(a)		
16:25A	Soil erosion and sediment control standards	25 N.J.R. 1479(a)	R.1993 d.276	25 N.J.R. 2496(a)
16:28	Speed limits for State highways	25 N.J.R. 1479(b)	R.1993 d.257	25 N.J.R. 2496(b)
16:28-1.41	Speed limit zones along U.S. 9 in Berkeley Township and Pine Beach Borough	25 N.J.R. 1834(a)	R.1993 d.327	25 N.J.R. 2913(c)
16:28-1.48, 1.93	Speed rates along Route 167 in Port Republic and Route 44 in Greenwich and West Deptford	25 N.J.R. 2225(a)		
16:28-1.108	School zone along Route 82 in Union Township	25 N.J.R. 1061(b)	R.1993 d.214	25 N.J.R. 1988(a)
16:28A-1.1, 1.7, 1.17, 1.23, 1.32, 1.36	Restricted parking and stopping along U.S. 1 Business in Mercer County, U.S. 9 in Ocean and Monmouth counties, Routes 26 and 33 in Middlesex County, U.S. 46 in Warren and Morris counties, and Route 57 in Warren County	25 N.J.R. 2226(a)		
16:28A	Restricted parking and stopping	25 N.J.R. 1479(b)	R.1993 d.257	25 N.J.R. 2496(b)
16:28A-1.6, 1.7, 1.33, 1.41, 1.52, 1.57	Restricted parking and stopping on Route 7 in Nutley, U.S. 9 in Galloway Township, Route 47 in Vineland, Route 77 in Bridgeton, Route 173 in Bethlehem, and U.S. 206 in Lawrence Township	25 N.J.R. 2649(a)		
16:28A-1.6, 1.9, 1.38	Restricted parking along Route 7 in Belleville, Route 17 in North Arlington, and Route 71 in Bradley Beach	25 N.J.R. 1062(a)	R.1993 d.213	25 N.J.R. 1988(b)
16:28A-1.19, 1.98	Parking restrictions along Route 28 in Somerville and Route 56 in Pittsgrove Township	25 N.J.R. 1836(a)	R.1993 d.328	25 N.J.R. 2914(a)
16:28A-1.36, 1.41	Parking restrictions along Route 57 in Warren County and Route 77 in Bridgeton	25 N.J.R. 1835(a)	R.1993 d.329	25 N.J.R. 2915(a)
16:28A-1.41	No stopping or standing zones along Route 77 in Bridgeton	25 N.J.R. 1063(a)	R.1993 d.216	25 N.J.R. 1989(a)
16:29	No passing	25 N.J.R. 1479(b)	R.1993 d.257	25 N.J.R. 2496(b)
16:30	Miscellaneous traffic rules	25 N.J.R. 1479(b)	R.1993 d.257	25 N.J.R. 2496(b)
16:30-3.8	Shoulder use lane along I-195 in Millstone Township	25 N.J.R. 2651(a)		
16:30-6.3	Weight limit restriction for trucks using Route 173 in Bloomsbury, Hunterdon County	25 N.J.R. 1838(a)	R.1993 d.330	25 N.J.R. 2916(a)
16:30-10.1	Midblock crosswalk on Route 28 in Somerville	25 N.J.R. 1838(b)	R.1993 d.331	25 N.J.R. 2916(b)
16:31	Turns	25 N.J.R. 1479(b)	R.1993 d.257	25 N.J.R. 2496(b)
16:31-1.31	Turning restrictions along U.S. 1 Business in Lawrence Township	25 N.J.R. 1064(a)	R.1993 d.215	25 N.J.R. 1989(b)
16:31A	Prohibited right turns on red	25 N.J.R. 1479(b)	R.1993 d.257	25 N.J.R. 2496(b)
16:44	Construction services	25 N.J.R. 1954(a)		
16:44	Construction Services: waiver of sunset provision of Executive Order No. 66(1978)	25 N.J.R. 2227(a)		
16:47-3.8, 3.16, 4.3, 4.6, 4.7, 4.13–4.16, 4.19, 4.27, 4.30, 4.33, 4.41, 5.2, App. B, C, D, E, N, N-1, N-2	State Highway Access Management Code: access standards; permits	25 N.J.R. 903(a)	R.1993 d.210	25 N.J.R. 1990(a)
16:49-1.3, 1.5, 2.1, App.	Transportation of hazardous materials	25 N.J.R. 1065(a)	R.1993 d.235	25 N.J.R. 2497(a)
16:53-3.2	Autobus dimensions	25 N.J.R. 459(a)	R.1993 d.190	25 N.J.R. 1885(a)

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16:53-7.25, 7.26, 7.27	Autobus trolleys: safety standards	24 N.J.R. 4500(a)	R.1993 d.191	25 N.J.R. 1885(b)
16:53C	Rail freight program	25 N.J.R. 1481(a)	R.1993 d.277	25 N.J.R. 2503(a)
16:54	Licensing of aeronautical and aerospace facilities	24 N.J.R. 2542(a)	R.1993 d.348	25 N.J.R. 2916(c)
16:54	Licensing of aeronautical and aerospace facilities: extension of comment period	24 N.J.R. 3026(a)		
16:54	Licensing of aeronautical and aerospace facilities: extension of comment period	24 N.J.R. 4025(a)		
16:55	Licensing of aeronautical activities	25 N.J.R. 1483(a)	R.1993 d.278	25 N.J.R. 2505(a)
16:60	Office of Aviation: issuance of summons and designation of law enforcement officer	25 N.J.R. 1484(a)	R.1993 d.279	25 N.J.R. 2505(b)
16:61	Aircraft accidents	25 N.J..R 1485(a)	R.1993 d.280	25 N.J.R. 2505(c)
	Most recent update to Title 16: TRANSMITTAL 1993-4 (supplement April 19, 1993)			
TREASURY-GENERAL—TITLE 17				
17:1	Division of Pensions and Benefits: administration of public employee retirement systems and benefit programs	25 N.J.R. 1955(a)		
17:1-10, 11	State Prescription Drug Program; Dental Expenses Program (recodify to 17:9-8, 9)	25 N.J.R. 675(b)		
17:2-4.3	Public Employees' Retirement System: school year members	25 N.J.R. 908(a)	R.1993 d.296	25 N.J.R. 2701(a)
17:9	State Health Benefits Program	25 N.J.R. 2651(b)		
17:9-1.5	State Health Benefits Program: local employer reentry	25 N.J.R. 460(a)	R.1993 d.269	25 N.J.R. 2505(d)
17:9-2.3	State Health Benefits Program: annual enrollment periods	24 N.J.R. 4025(b)	R.1993 d.259	25 N.J.R. 2506(a)
17:9-2.4	State Health Benefits Program: retirement or COBRA enrollment	24 N.J.R. 4025(c)	R.1993 d.249	25 N.J.R. 2506(b)
17:9-2.4	State Health Benefits Program: reinstatement of prior coverage after return from approved leave of absence	25 N.J.R. 1671(b)	R.1993 d.349	25 N.J.R. 2899(a)
17:9-4.1, 4.5	State Health Benefits Program: "appointive officer" eligibility	24 N.J.R. 3493(a)		
17:10	Judicial Retirement System	25 N.J.R. 1956(a)		
17:16-33.1	State Investment Council: repurchase agreement of securities broker	25 N.J.R. 909(a)	R.1993 d.188	25 N.J.R. 1886(a)
17:16-42.2	State Investment Council: dividend requirement for eligible stock issuers	25 N.J.R. 909(b)	R.1993 d.189	25 N.J.R. 1886(b)
17:20	Lottery Commission rules	25 N.J.R. 1347(b)	R.1993 d.310	25 N.J.R. 2701(b)
17:32	State Planning Rules	25 N.J.R. 461(a)	R.1993 d.165	25 N.J.R. 1886(c)
17:32-7	State Development and Redevelopment Plan: voluntary submission of municipal and county plans for consistency review	25 N.J.R. 1839(a)		
	Most recent update to Title 17: TRANSMITTAL 1993-4 (supplement April 19, 1993)			
TREASURY-TAXATION—TITLE 18				
18:2-3	Payment of taxes by electronic funds transfer	25 N.J.R. 1078(a)		
18:7-1.16	Corporation Business Tax: financial businesses	25 N.J.R. 1841(a)		
18:7-13.8	Corporation Business Tax: claims for refund	25 N.J.R. 1842(a)		
18:9	Business Personal Property Tax	25 N.J.R. 1485(a)	R.1993 d.312	25 N.J.R. 2899(b)
18:12	Local property tax rules: preparation of tax lists; revaluation; appeals; homestead rebate; exemptions	25 N.J.R. 2652(a)		
18:12-10.1, 10.2, 10.3	Local property tax: classification of real and personal property	25 N.J.R. 61(a)		
18:12A-18:17	Local property taxation: county boards; senior citizens' deduction; farmland assessment; realty transfer fee; assessor qualification	25 N.J.R. 2653(a)		
18:24	Sales and Use Tax	25 N.J..R 1486(a)	R.1993 d.313	25 N.J.R. 2899(c)
18:26	Transfer Inheritance Tax and Estate Tax	25 N.J.R. 1498(a)	R.1993 d.314	25 N.J.R. 2906(a)
18:35	Gross Income Tax; setoff of individual liability	25 N.J.R. 1500(a)	R.1993 d.315	25 N.J.R. 2906(b)
18:35-1.14, 1.25	Gross Income Tax: partnerships; net profits from business	25 N.J.R. 677(a)		
18:35-1.17	Gross income tax: Health Care Subsidy Fund withholding	25 N.J.R. 1957(a)		
18:35-1.27	Gross Income Tax: interest on overpayments	24 N.J.R. 2419(a)		
	Most recent update to Title 18: TRANSMITTAL 1993-3 (supplement April 19, 1993)			
TITLE 19—OTHER AGENCIES				
19:3, 3B, 4, 4A	Hackensack Meadowlands District rules	24 N.J.R. 4503(a)	R.1993 d.176	25 N.J.R. 1887(a)
19:8	Use and administration of Garden State Parkway	25 N.J..R 1500(b)	R.1993 d.290	25 N.J.R. 2701(c)
19:9-1.9	Turnpike Authority: double bottom trailer permits	25 N.J.R. 684(a)	R.1993 d.311	25 N.J.R. 2906(c)
19:9-2.7	Turnpike Authority construction contracts: withdrawal of bid for unilateral mistake	25 N.J.R. 62(b)	R.1993 d.326	25 N.J.R. 2906(d)
19:17	PERC Appeal Board rules	25 N.J.R. 1842(b)	R.1993 d.322	25 N.J.R. 2907(a)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
19:25-15.3–15.6, 15.10, 15.11, 15.12, 15.14, 15.16, 15.17, 15.21, 15.22, 15.24, 15.27-15.32, 15.35, 15.43, 15.45, 15.48, 15.49, 15.50, 15.54, 15.64, 15.65	ELEC: public financing of general election candidates for Governor	25 N.J.R. 910(a)	R.1993 d.207	25 N.J.R. 1994(a)
19:25-15.17, 15.48	Public financing of general election candidates for Governor	25 N.J.R. 1957(b)		
19:30-6.4	Economic Development Authority: fee for modifying or restructuring loan payment terms	25 N.J.R. 916(a)	R.1993 d.217	25 N.J.R. 1998(a)
	Most recent update to Title 19: TRANSMITTAL 1993-4 (supplement April 19, 1993)			
TITLE 19 SUBTITLE K—CASINO CONTROL COMMISSION/CASINO REINVESTMENT DEVELOPMENT AUTHORITY				
19:40-2.5	Delegation of Commission authority	24 N.J.R. 2348(a)		
19:40-2.6	Post-employment restrictions on former Commission and Division of Gaming Enforcement employees	25 N.J.R. 1501(a)	R.1993 d.291	25 N.J.R. 2702(a)
19:40-5.2	Practice of law before Commission	25 N.J.R. 1672(a)	R.1993 d.316	25 N.J.R. 2907(b)
19:40-6	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1503(a)		
19:41	Applications	25 N.J.R. 916(b)	R.1993 d.205	25 N.J.R. 1999(a)
19:41-5, 7.14	Applicant disclosure forms	25 N.J.R. 2655(a)		
19:41-9.1, 9.4	Fee policy	25 N.J.R. 1080(a)	R.1993 d.253	25 N.J.R. 2506(c)
19:42	Hearings	25 N.J.R. 1082(a)	R.1993 d.222	25 N.J.R. 1999(b)
19:42-5.3	Professional practice: multiple party representation	25 N.J.R. 1082(b)		
19:43-4.1	Casino bankroll	25 N.J.R. 1672(b)	R.1993 d.317	25 N.J.R. 2907(c)
19:44	Gaming schools	25 N.J.R. 2660(a)		
19:44-3.2	Statement of gaming school proposal	25 N.J.R. 2655(a)		
19:44-8.3	Dealer instruction: administrative correction	_____	_____	25 N.J.R. 2507(a)
19:44-8.3	Poker	25 N.J.R. 2236(a)		
19:45-1.1, 1.2, 1.11, 1.12, 1.14, 1.15, 1.16, 1.20, 1.24, 1.24A, 1.24B, 1.25, 1.25A–1.25I, 1.26, 1.27, 1.27A, 1.28, 1.29, 1.33, 1.34	Authorized financial statements: acceptance and processing	24 N.J.R. 3232(a)		
19:45-1.1, 1.2, 1.11, 1.12, 1.20	Poker	25 N.J.R. 2236(a)		
19:45-1.1, 1.10, 1.32, 1.36, 1.37, 1.38, 1.42, 1.43, 1.44	Use and operation of drop buckets in slot machines	25 N.J.R. 1503(b)	R.1993 d.318	25 N.J.R. 2908(a)
19:45-1.1, 1.40	Jackpot payouts not paid directly from slot machine	25 N.J.R. 2227(b)		
19:45-1.12	Pai gow poker personnel: administrative correction	_____	_____	25 N.J.R. 2507(a)
19:45-1.12, 1.14, 1.15, 1.46	Currency and coupon exchange on casino floor	25 N.J.R. 1673(a)	R.1993 d.319	25 N.J.R. 2911(a)
19:45-1.12A	Minimum and maximum gaming wagers	25 N.J.R. 1958(a)		
19:45-1.19	Acceptance of tips by dealers and pari-mutuel cashiers	25 N.J.R. 1674(a)	R.1993 d.320	25 N.J.R. 2913(a)
19:45-1.19	Card-o-lette	25 N.J.R. 2230(a)		
19:45-1.40	Jackpot payout slips	25 N.J.R. 917(a)	R.1993 d.292	25 N.J.R. 2702(b)
19:45-1.43	Counting and recording contents of slot drop buckets: administrative correction	_____	_____	25 N.J.R. 2913(b)
19:46	Gaming equipment	25 N.J.R. 918(a)	R.1993 d.204	25 N.J.R. 1999(c)
19:46-1.1, 1.8, 1.9, 1.13F, 1.20	Card-o-lette	25 N.J.R. 2230(a)		
19:46-1.5	Gaming chips not in active use	25 N.J.R. 2233(a)		
19:46-1.6	Storage of gaming chips and plaques	25 N.J.R. 1083(a)	R.1993 d.254	25 N.J.R. 2508(a)
19:46-1.10	Multiple action blackjack	25 N.J.R. 2234(a)		
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19:46-1.18, 1.19	Pai gow poker: dealing from the hand	24 N.J.R. 4247(a)	R.1993 d.192	25 N.J.R. 1887(b)
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