2. That the company has provided its agents with information about the expense allocation method used by the company in its illustrations and disclosed as required in (c)6 above.

(g) The annual certifications shall be provided to the Commissioner each year by a date determined by the insurer. Subsequent annual certifications shall be provided by the anniversary date of the initial annual certification, or a request to change the date of certification with a full explanation of the basis of the request shall be filed by that date. The original certification shall be mailed to the following address:

New Jersey Department of Banking and Insurance
Division of Enforcement and Consumer
Protection
P.O. Box 329
Trenton, New Jersey 08625-0329

(h) If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the insurer shall notify the Commissioner within 10 days and disclose the reason for the change.

Amended by R.2007 d.392, effective December 17, 2007.
See: 39 N.J.R. 3711(a), 39 N.J.R. 5346(a).
In the introductory paragraph of (g), substituted "certification" for "certifications" in the last sentence; in the language following (g), deleted the address for "New Jersey Department of Banking and Insurance Life and Health Division" and the phrase "One copy of the certifications shall be mailed to the following address:"; and in (h), deleted "of the fact" following "Commissioner".

11:4-52.10 Penalties

In addition to any other penalties provided by the laws of this State, an insurer or producer that violates a requirement of these rules shall be guilty of a violation of N.J.A.C. 11:2-17.

11:4-52.11 Transition

(a) Until January 1, 1999, insurers may use the following language instead of the statement required by N.J.A.C. 11:4-52.5(d)1: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed." After January 1, 1999, insurers shall comply with the requirements of N.J.A.C. 11:4-52.5(d)1.

(b) Until January 1, 1999, insurers may use the language set forth in the NAIC Life Insurance Illustrations Model Regulation at Section 9B(1), incorporated herein by reference, which includes an acknowledgement by the applicant that no illustration conforming to the policy applied for was provided and that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. After January 1, 1999, insurers shall comply with the requirements of N.J.A.C. 11:4-52.7(c).

SUBCHAPTER 53. MINIMUM STANDARDS FOR SPECIFIED DISEASE AND CRITICAL ILLNESS COVERAGES

11:4-53.1 Purpose and scope

(a) The purpose of this subchapter is to:

1. Permit the sale of specified disease and critical illness coverage in New Jersey;

2. Provide for reasonable standardization of coverage and the simplification of terms and benefits of specified disease and critical illness policies;

3. Facilitate comparison of specified disease and critical illness policies in order to increase public understanding;

4. Prohibit policy provisions that may be misleading or confusing in connection with the purchase of specified disease and critical illness policies or with the settlement of claims;

5. Restrict provisions that may be contrary to the health care needs of the public;

6. Prohibit coverages that are so limited in scope as to be of no substantial economic value to the holders thereof; and

7. Provide for full disclosure in the sale of specified disease and critical illness policies.

(b) This subchapter shall apply to:

1. All specified disease policies and critical illness policies, as defined by this subchapter, delivered or issued for delivery in this State;

2. All certificates, as defined by this subchapter, issued under group specified disease or critical illness policies, which certificates have been delivered or issued for delivery in this State; and

3. All carriers, as defined in this subchapter, delivering or issuing for delivery specified disease or critical illness policies in this State, or delivering or issuing for delivery certificates in this State, which certificates were issued under a group specified disease or critical illness policy.

11:4-53.2 Definitions

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

"Aggregate loss ratio" means the ratio of the accumulated value of past paid benefits (from the original effective date of the form to the date as of which the ratio is determined) and the present value of future paid benefits to the accumulated value of past paid premiums (from the original effective date of the form to the date as of which the ratio is determined)

and the present value of future paid premiums. Benefits shall not be increased nor premiums reduced by actual or anticipated dividends, and interest shall be included in the accumulated and present values on the same basis as in the present values of the anticipated loss ratio. For purposes of this ratio, no reserves shall be included in the benefits or premiums.

"Anticipated loss ratio" means the ratio of the present value of the expected paid benefits, not including dividends, to the present value of the expected paid premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. For purposes of this ratio, the present values must incorporate realistic rates of interest that are determined before Federal taxes but after investment expenses. Benefits and premiums shall be discounted from the year of payment, with reasonable assumptions as to time of payment within the year. For purposes of this ratio, no reserves shall be included in the benefits or premiums.

"Carrier" means any insurance company operating pursuant to N.J.S.A. 17B:17-1 et seq., or fraternal benefit society operating pursuant to N.J.S.A. 17:44-1 et seq., transacting or authorized to transact the business of health insurance in the State of New Jersey.

"Certificate" means a statement of the coverage and provisions of a policy of group specified disease or critical illness coverage, which has been delivered or issued for delivery in New Jersey, and includes riders, endorsements and enrollment forms, if any.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Critical illness coverage" means coverage that pays a level lump sum benefit upon diagnosis of a specified disease without payment of further benefits in connection with hospital and medical care for the treatment of the specified disease.

"Department" means the New Jersey Department of Banking and Insurance.

"Policy," "policy form," or "form" means any policy, contract, rider, certificate or other document that sets forth or summarizes the essential features of the coverage issued to an individual or group by a carrier.

"Specified disease coverage" means coverage that pays fixed-sum benefits on an indemnity non-expense incurred basis in connection with hospital or medical care for the treatment of a specifically named disease or diseases that are life threatening in nature.

11:4-53.3 General standards

(a) No carrier shall deliver or issue for delivery in this State any specified disease or critical illness policy unless its policy form, and its rates where required by N.J.S.A. 17B:26-1, have been approved by the Commissioner pursuant to the procedures set forth at N.J.A.C. 11:4-40.

(b) The following approval standards shall apply to all specified disease and critical illness policies delivered or issued for delivery in this State:

1. No policy shall be sold or offered for sale other than as specified disease or critical illness coverage pursuant to this subchapter.

2. Any policy that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate or life threatening, a clinical diagnosis will be accepted instead.

3. An individual policy containing specified disease coverage shall be guaranteed renewable for life.

4. Except as permitted by N.J.S.A. 17B:26-19 regarding other insurance with this carrier, benefits shall be paid regardless of other coverage.

5. Except in the case of direct response carriers, no policy shall be delivered or issued for delivery in this State unless the outline of coverage form set forth as Exhibit A in the Appendix to this subchapter, incorporated herein by reference, describing the policy's benefits, limitations and exclusions, and anticipated loss ratio, is delivered to the applicant at the time application is made, and written acknowledgment of receipt or certification of delivery of such outline of coverage is provided to the carrier. Direct response carriers shall deliver the requisite outline of coverage no later than at the time the policy is issued or delivered.

6. The only permissible preexisting condition limitations are those that exclude coverage for no more than six months after the effective date of coverage under the policy, for a condition for which medical advice was given or treatment was recommended by, or received from, a licensed health care provider within the six-month period immediately preceding the effective date of coverage.

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

8. The first page of every policy shall contain, in at least 14 point type but not less than the size of type used for policy captions, and in capital letters, a prominent statement, as follows: "THIS IS A LIMITED POLICY (OR CERTIFICATE). IT PAYS BENEFITS FOR (NAME OF SPECIFIED DISEASES) ONLY AND DOES NOT PROVIDE COVERAGE FOR ANY OTHER MEDICAL CONDITIONS. YOU SHOULD MAINTAIN SEPARATE COMPREHENSIVE HEALTH COVERAGE. READ THIS POLICY CAREFULLY WITH THE OUTLINE OF COVERAGE."

9. Application forms shall include a question to determine whether the applicant has other coverage providing benefits for hospital and medical services and supplies. If the applicant does not respond affirmatively to such question, the policy shall not be issued.

10. Every policy shall be issued only to persons who are covered by insurance that provides benefits for hospital and medical services and supplies.

11. No policy shall provide for a reduction of benefits upon attainment of any age or other condition, or upon the occurrence of any event(s).

12. No policy shall provide for a probationary or waiting period during which no coverage is provided under the policy.

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

11:4-53.4 Standards for specified disease coverage

(a) Specified disease policies shall provide the following minimum benefits:

1. A fixed-sum benefit of at least $100.00 for each day of hospital confinement for at least 365 days; and

2. A fixed-sum benefit equal to at least one-half of the benefit for hospital confinement, for each day of hospital or non-hospital outpatient surgery or other medically appropriate outpatient treatment, including but not limited to chemotherapy and radiation therapy, for at least 365 days.

(b) Benefits for confinement in a skilled nursing home or for home health care are optional. If a policy provides these benefits, the policy shall provide a fixed sum benefit of at least one-fourth of the daily benefit amount payable for hospital confinement for each day of skilled nursing home confinement for at least 100 days, and for each day of home health care for at least 100 days.

(c) A lump sum payment at least equal to $1,000 may be made to cover non-medical costs such as travel, lodging, household costs, and other living expenses.

(d) Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of the covered disease is made at some later date.

(e) No policy shall contain any requirement that the covered person under the policy must incur an expense in order for benefits to be paid.

11:4-53.5 Standards for critical illness coverage

(a) The total benefit amounts available under the policy shall only be available in increments of $1,000. As long as the policy clearly indicates, in cases of clearly identifiable forms of diseases with significantly lower treatment costs, lesser amounts may be provided, but in no event shall amounts be less than 25 percent of the largest benefit amount under the policy.

(b) The benefit shall be payable upon initial and medically appropriate diagnosis of a specified disease covered by the policy. There shall be no requirement that the insured survive for any period of time in order for the benefit to be payable.

11:4-53.6 Loss ratio standards

(a) In order to assure that benefits are reasonable in relation to the premium charged, the minimum loss ratio for specified disease and critical illness policies shall be as follows:

1. For group policies, at least 75 percent;

2. For individual policies, at least 60 percent.

(b) With respect to filings of rate revisions for previously approved policy forms, benefits shall be deemed reasonable in relation to premiums if both the anticipated loss ratio and the aggregate loss ratio satisfy these loss ratio standards.

(c) Carriers shall include with the initial submission of rates for a new policy an actuarial memorandum which shall include the following:

1. The anticipated loss ratio;

2. The specific formulas and methodology used in calculating gross premiums;

3. An explanation and documentation supporting the premium assumptions;

4. The objective basis for rate differentials; and

5. A certification signed by the carrier's actuary that the information contained in the actuarial memorandum is appropriate and that the benefits provided are reasonable in relation to the premiums charged.

(d) The actuarial memorandum submitted to the Department pursuant to (c) above shall be confidential and shall not be considered a public record or disclosed by the Department to any person.

(e) Carriers shall submit for filing with the Commissioner annually on or before June 30 one report for each policy form for which policies issued in New Jersey remain in force in accordance with the applicable reporting form set forth as Exhibit B in the Appendix to this subchapter, incorporated herein by reference.

(f) If the loss ratio for a policy, based on a substantial volume of reasonably mature business, does not meet the standards set forth in (a) above, the carrier shall be required to explain why the premium should not be regarded as unreasonably high in relation to the benefits provided. After consideration of the explanation and any additional information furnished by the carrier, the Department shall inform the carrier if the benefits provided are considered unreasonable in relation to the premium charged. If within 90 days thereafter the carrier does not reduce the premium or increase the benefits provided in the policy such that the standards set forth in (a) above are met, the Department may take action and/or impose penalties as may be appropriate pursuant to law. Such action may include the Department's requiring that an independent audit of the carrier's loss ratio be conducted at the carrier's expense.

Amended by R.2002 d.7, effective January 7, 2002.
See: 33 N.J.R. 3425(a), 34 N.J.R. 283(a).
Amended minimum loss ratio for individual policies from 65 to 60 percent.

11:4-53.7 Advertising

All advertisements shall comply with the standards set forth at N.J.A.C. 11:2-11 (the Department's Rules Governing Advertisement of Health Insurance) and any other disclosure and advertising rules which may be applicable to carriers.

Amended by R.2011 d.007, effective January 3, 2011.
See: 42 N.J.R. 1845(a), 43 N.J.R. 54(b).
Deleted (a) and (c); and deleted designation (b).

APPENDIX

EXHIBIT A

(a) To comply with N.J.A.C. 11:4-53.3(b)5, specified disease and critical illness policies meeting the definitions of those terms contained in N.J.A.C. 11:4-53.2 shall use the following statements only, except that appropriate policy identification may be included:

COMPANY NAME

SPECIFIED DISEASE COVERAGE ONLY (CRITICAL ILLNESS COVERAGE ONLY)

OUTLINE OF COVERAGE

This policy or certificate is (an individual policy of insurance) (a group policy or certificate). This policy or certificate provides specified disease coverage (critical illness coverage) ONLY. This policy or certificate does NOT provide comprehensive medical or hospital insurance, Medicare supplement insurance, long-term care insurance, nursing home insurance only, home health care insurance only, or nursing home and home care insurance. You may also contact your local social security office or this company and obtain a copy of the Guide to Health Insurance for People with Medicare.

(Accurately list benefits, exclusions, reductions and limitations of the policy or certificate in a manner which does not misrepresent the actual coverage provided.)

This outline of coverage is a very brief summary of your policy or certificate.

The policy or certificate itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR POLICY OR CERTIFICATE carefully.

The anticipated loss ratio for this policy or certificate is *(indicate either 75 percent for group policies, or 60 percent for individual policies)*. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy or certificate.