CHAPTER 4

ACTUARIAL SERVICES

Authority

N.J.S.A. 17:1-8.1, 17:1-15(e), 17:1C-6e, 17:48-8.1 and 17B:27E-9, and P.L. 2003, c. 207

Source and Effective Date

R.2001 d.7, effective November 30, 2000.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 4, Actuarial Services, expires on May 29, 2006. See: 37 N.J.R. 4859(a).

Chapter Historical Note

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

Subchapter 2, Replacement of Life Insurance Policy, was adopted as R.1972 d.21, effective April 1, 1972.

Subchapter 7, Procedure for the Regulation of Consent to Higher Rate Filings, was adopted as R.1973 d.82, effective April 15, 1973. See: 4 N.J.R. 220(a), 5 N.J.R. 113(b).

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

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

Subchapter 13, Group Student Health Insurance, was adopted as R.1977 d.309, effective August 22, 1977. See: 9 N.J.R. 343(c), 9 N.J.R. 438(d).

Subchapter 14, Home Health Care Insurance Coverage, was adopted as R.1977 d.476, effective December 15, 1977. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

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

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

Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings, were adopted as new rules by R.1980 d.176, effective April 21, 1980. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c).

Pursuant to Executive Order No. 66(1978), Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings, were readopted as R.1980 d.343, effective August 5, 1980. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b).

Subchapter 21, Limited Death Benefits Forms, was adopted as R.1980 d.265, effective June 18, 1980. See: 12 N.J.R. 279(b), 12 N.J.R. 423(c).

Subchapter 2, Replacement of Life Insurance Policy, was repealed and Subchapter 2, Replacement of Life Insurance Policy, was adopted as new rules by R.1982 d.16, effective February 1, 1982, operative June 1, 1982.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

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

Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables, was adopted as R.1984 d.478, effective November 5, 1984. See: 16 N.J.R. 1452(a), 16 N.J.R. 3040(a).

Pursuant to Executive Order No. 66(1978), Subchapter 6, Reserve Standards for Individual Health Insurance Policies, was readopted as R.1984 d.512, effective November 5, 1984. See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Subchapter 23, Medicare Supplement Policies and Contracts, was adopted as R.1985 d.70, effective February 19, 1985, operative June 19, 1985. See: 16 N.J.R. 2945(a), 17 N.J.R. 460(a).

Pursuant to Executive Order No. 66(1978), Subchapter 20, Blindness; Partial Blindness or Other Physical or Mental Impairments; Unfair Discrimination, was readopted as R.1985 d.161, effective April 1, 1985. See: 17 N.J.R. 168(a), 17 N.J.R. 820(a).

Pursuant to Executive Order No. 66(1978), Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings were readopted as R.1985 d.221, effective April 15, 1985. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a).

Subchapter 21 was readopted as R.1985 d.325, effective June 3, 1985. See: 17 N.J.R. 891(a), 17 N.J.R. 1660(a).

Subchapter 24, Smoker and Nonsmoker Mortality Tables, was adopted as R.1985 d.617, effective December 2, 1985. See: 17 N.J.R. 2348(a), 17 N.J.R. 2907(a).

Subchapter 26, Annuity Mortality Tables, was adopted as R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 290(a).

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

Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, was adopted as R.1988 d.455, effective September 19, 1988. See: 20 N.J.R. 43(a), 20 N.J.R. 2377(c).

Subchapter 28, Group Coordination of Benefits, was adopted as new rules by R.1988 d.499, effective October 17, 1988. See: 20 N.J.R. 1773(b), 20 N.J.R. 2581(a).

Subchapter 29, Homeowners Comparison Survey, was adopted as R.1989 d.50, effective January 17, 1989. See: 20 N.J.R. 2181(a), 21 N.J.R. 164(a).

Subchapter 31, Term Life Insurance Comparison Survey, was adopted as R.1989 d.122, effective February 21, 1989. See: 20 N.J.R. 2990(a), 21 N.J.R. 566(a).

Subchapter 32, Health Service Corporation Notice of Increased Rates, was adopted as R.1989 d.522, effective October 2, 1989. See: 21 N.J.R. 973(b), 21 N.J.R. 3173(c).

Subchapter 33, Excess Interest Reserve Adjustment, was adopted as R.1989 d.523, effective October 2, 1989. See: 21 N.J.R. 1308(a), 21 N.J.R. 3175(c).

Subchapter 34, Long-Term Care Insurance, was adopted as R.1989 d.571, effective November 6, 1989. See: 21 N.J.R. 1964(a), 21 N.J.R. 3465(a).

Subchapter 25, Medicare Supplement Interim Standards, was adopted as R.1990 d.214, effective April 16, 1990. See: 22 N.J.R. 320(a), 22 N.J.R. 1266(b).

Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1991 d.3, effective November 30, 1990, Subchapter 1, Contracts on a Variable Basis, was repealed by R.1991 d.3, effective January 7, 1991. See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).

Subchapter 35, Annual Medicare Supplement Policy Survey, was adopted as R.1991 d.122, effective March 4, 1991. See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a).

Petition for Rulemaking. See: 23 N.J.R. 2546(c), 23 N.J.R. 3827(a).

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

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

Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures, was adopted as R.1995 d.406, effective August 7, 1995. See: 27 N.J.R. 1356(b), 27 N.J.R. 2931(a).

Subchapter 30, Accelerated Death Benefits, was adopted as R.1995 d.521, effective September 18, 1995. See: 27 N.J.R. 2046(a), 27 N.J.R. 3613(c).

Subchapter 40, Life/Health/Annuity Forms, was adopted as R.1995 d.569, effective November 6, 1995. See: 27 N.J.R. 2857(a), 27 N.J.R. 2867(a), 27 N.J.R. 4317(a).

Administrative correction. See: 27 N.J.R. 4728(a).

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.1996 d.4, effective November 30, 1995, and Subchapter 5, Amendment to Instructions to Life and Accident and Health Annual Statement Blank, Subchapter 10, Expense Experience, Subchapter 32, Health Service Corporation Notice of Increased Rates, Subchapter 35, Annual Medicare Supplement Policy Survey, and Exhibits A and B of the Appendix to Subchapters 16 and 23 were repealed by R.1996 d.4, effective January 2, 1996. See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Subchapter 47, Actuarial Requirements for Flexible-Factor Policy Forms, was adopted as new rules by R.1996 d.83, effective February 5, 1996. See: 27 N.J.R. 3750(a), 28 N.J.R. 1215(a).

Subchapter 44, Standards for Contracts on a Variable Basis, was adopted as new rules by R.1996 d.149, effective March 18, 1996. See: 27 N.J.R. 3743(a), 28 N.J.R. 1546(a).

Subchapter 45, Periodic Reports, was adopted as new rules by R.1996 d.150, effective March 18, 1996. See: 27 N.J.R. 3744(a), 28 N.J.R. 1548(a).

Subchapter 43, Individual Annuity Contract Form Standards, was adopted as new rules by R.1996 d.181, effective April 1, 1996. See: 27 N.J.R. 3740(a), 28 N.J.R. 1885(a).

Subchapter 48, Unfair Discrimination, was adopted as new rules by R.1996 d.182, effective April 1, 1996. See: 27 N.J.R. 3756(a), 28 N.J.R. 1887(a).

Subchapter 23A, Medicare Supplement—Under 50 Coverage, and Subchapter 23B, Medicare Supplement—Age 50 through 64 Coverage were adopted as new rules by R.1996 d.195, effective April 15, 1996. See: 27 N.J.R. 3719(a), 28 N.J.R. 1987(a).

Subchapter 42, Group Life, Group Health and Blanket Insurance: General Standards for Contract Provisions, was adopted as new rules by R.1996 d.196, effective April 15, 1996. See: 27 N.J.R. 3735(a), 28 N.J.R. 2003(a).

Subchapter 41, Standards for Individual Life Insurance Policy Forms, was adopted as new rules by R.1996 d.197, effective April 15, 1996. See: 27 N.J.R. 3727(a), 28 N.J.R. 1992(a).

Subchapter 25, Funeral Insurance Policies, was adopted as new rules by R.1996 d.328, effective July 15, 1996. See: 288 N.J.R. 1656(a), 28 N.J.R. 3671(a).

Subchapter 49, Mandated Diabetes Benefits, was adopted as new rules by R.1997 d.86, effective February 18, 1997. See: 28 N.J.R. 4340(a), 29 N.J.R. 562(a).

Subchapter 46, Synthetic Guaranteed Investment Contract Forms, was adopted as new rules by R.1997 d.332, effective August 4, 1997. See: 29 N.J.R. 1472(a), 29 N.J.R. 3452(b).

Subchapter 50, Reimbursement of Inmate Health Care Costs, was adopted as new rules by R.1997 d.513, effective December 1, 1997. See: 29 N.J.R. 2232(a), 29 N.J.R. 5066(a).

Subchapter 52, Life Insurance Illustrations, was adopted as new rules by R.1998 d.338, effective July 6, 1998. See: 30 N.J.R. 47(a), 30 N.J.R. 2495(a).

Subchapter 32, Valuation of Life Insurance Policies, was adopted as new rules by R.1999 d.442, effective December 20, 1999 (operative January 1, 2000, except as provided in N.J.A.C. 11:4-32.6). See: 31 N.J.R. 2845(a), 31 N.J.R. 4268(c).

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.2001 d.7, effective November 30, 2000. See: Source and Effective Date.

Subchapter 54, Benefit Standards for Infertility Coverage, was adopted as new rules by R.2003 d.160, effective April 21, 2003. See: 34 N.J.R. 2521(a), 35 N.J.R. 1692(b).

Subchapter 34, Long-Term Care Insurance, was repealed and Subchapter 34, Long-Term Care Insurance, was adopted as new rules by R.2005 d.422, effective December 19, 2005. See: 36 N.J.R. 5195(a), 37 N.J.R. 5014(b).

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. NEW JERSEY INSOLVENT HEALTH MAINTENANCE ORGANIZATION ASSISTANCE ASSOCIATION

Authority

N.J.S.A. 17:1-8.1; 17:1-15e; and 17B:32B-1 et seq.

Source and Effective Date

R.2001 d.122, effective April 2, 2001.
See: 32 N.J.R. 3907(a), 33 N.J.R. 1109(a).

11:4–3.5 Guaranteed annual endowments

Guaranteed annual endowments shall not be included as benefits in policies entitled to participate in dividends.

11:4–3.6 Severability

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

11:4–3.7 Effective date

The effective date of this regulation shall be August 1, 1963.

SUBCHAPTER 4. PASSBOOKS USED IN CONNECTION WITH COUPON POLICIES OR POLICIES CONTAINING GUARANTEED ANNUAL ENDOWMENT BENEFITS

11:4–4.1 General provisions

(a) Passbooks resembling those used for savings deposits in banks shall not be used in connection with policies to which this regulation applies which contain guaranteed annual endowment benefits.

(b) No reference shall be made in any material used in connection with such policies to "passbook" or "premium deposit" or other language which might give the impression to an applicant or person insured that the transaction involves premium deposits of a savings nature.

(c) The practice of using such books is determined to be an unfair method of competition and unfair or deceptive act or practice in the business of insurance in that it is a "statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby" as defined at N.J.S.A. 17B:30–3.

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

11:4–4.2 Unfair practice

The use of such books as described at N.J.A.C. 11:4–4.1(a) is determined to be an unfair method of competition and unfair or deceptive act or practice pursuant to N.J.S.A. 17B:30–18, and such books shall not be used in connection with policies to which this regulation applies.

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

11:4–4.3 Scope

(a) This practice shall be discontinued with respect to policies to which this regulation applies because it conflicts with N.J.S.A. 17B:25–5 which requires "that the policy constitute the entire contract between the parties".

(b) The reference to such language as "deposits" in such books, but not in the policy itself, is in conflict with the required provision that the policy constitute the entire contract.

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

11:4–4.4 Severability

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

11:4–4.5 Effective date

The effective date of this regulation shall be August 1, 1963.

SUBCHAPTER 5. (RESERVED)

SUBCHAPTER 6. MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE CONTRACTS

Authority

N.J.S.A. 17:1–8.1, 17:1–15e and 17B:19–5.

Source and Effective Date

R.2003 d.38, effective January 21, 2003.
See: 34 N.J.R. 3186(a), 35 N.J.R. 437(a).

Subchapter Historical Note

Subchapter 6, Reserve Standards for Individual Health Insurance Policies, was repealed and new Subchapter 6, Minimum Reserve Standards for Individual and Group Health Insurance Contracts, was adopted as R.2003 d.38, effective January 21, 2003. See: Source and Effective Date.

11:4–6.1 Purpose and scope

(a) This subchapter applies to all insurers authorized to write health insurance in this State. These standards apply to all individual and group health insurance coverage except credit insurance.

(b) When an insurer determines that adequacy of its health insurance reserves requires reserves in excess of the

minimum standards specified in this subchapter, such increased reserves shall be held and shall be considered the minimum reserves for that insurer.

(c) With respect to any block of contracts, or with respect to an insurer's health business as a whole, a prospective gross premium valuation is an important test of reserve adequacy as of a given valuation date. Such a gross premium valuation will take into account, for contracts in force, in a claims status, or in a continuation of benefits status on the valuation date, the present value as of the valuation date of: all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, adjusted for future premium increases reasonably expected to be put into effect.

(d) Such a gross premium valuation is to be performed whenever a significant doubt exists as to reserve adequacy with respect to any major block of contracts, or with respect to the insurer's health business as a whole. In the event inadequacy is found to exist, immediate loss recognition shall be made and the reserves restored to adequacy. Adequate reserves (inclusive of claim, premium and contract reserves, if any) shall be held with respect to all contracts, regardless of whether contract reserves are required for such contracts under these standards.

(e) Whenever minimum reserves, as defined in these standards, exceed reserve requirements as determined by a prospective gross premium valuation, such minimum reserves remain the minimum requirement under these standards.

(f) The following subchapter sets forth minimum standards for three categories of health insurance reserves:

1. Claim reserves;
2. Premium reserves; and
3. Contract reserves.

(g) Adequacy of an insurer's health insurance reserves is to be determined on the basis of all three categories combined. However, these standards emphasize the importance of determining appropriate reserves for each of the three categories separately.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).
Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

11:4-6.2 Definitions

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

"Annual-claim cost" means the net annual cost per unit of benefit before the addition of expenses, including claim settlement expenses, and a margin for profit or contingencies. For example, the annual claim cost for a $100.00 monthly disability benefit, for a maximum disability benefit period of one year, with an elimination period of one week, with respect to a male at age 35, in a certain occupation might be $12.00; while the gross premium for this benefit might be $18.00. The additional $6.00 would cover expenses and profit or contingencies.

"Claims accrued" means that portion of claims incurred on or prior to the valuation date which results in liability of the insurer for the payment of benefits for medical services which have been rendered on or prior to the valuation date, and for the payment of benefits for days of hospitalization and days of disability which have occurred on or prior to the valuation date, which the insurer has not paid as of the valuation date, but for which it is liable, and will have to pay after the valuation date. This liability is sometimes referred to as a liability for "accrued" benefits. A claim reserve (otherwise called a claim liability for annual statement reporting purposes), which represents an estimate of this accrued claim liability, must be established.

"Claims reported" means those claims that have been incurred and the insurer has been informed that they have been incurred. If the date reported is on or prior to the valuation date, the claim is considered as a reported claim for annual statement purposes.

"Claims unaccrued" means that portion of claims incurred on or prior to the valuation date which results in liability of the insurer for the payment of benefits for medical services expected to be rendered after the valuation date, and for benefits expected to be payable for days of hospitalization and days of disability occurring after the valuation date. This liability is sometimes referred to as a liability for unaccrued benefits. A claim reserve, which represents an estimate of the unaccrued claim payments expected to be made (which may or may not be discounted with interest), must be established.

"Claims unreported" means those claims that have been incurred on or before the valuation date, and the insurer has not been informed that they have been incurred. The claim is considered as an unreported claim for annual statement purposes.

"Date of disablement" means the earliest date the insured is considered as being disabled under the definition of disability in the contract, based on a doctor's evaluation or other evidence. Normally this date will coincide with the start of any elimination period.

"Elimination period" means a specified number of days, weeks, or months starting at the beginning of each period of loss, during which no benefits are payable.

(1) For contracts issued on or after January 1, 1955, and before January 1, 1986: The 1956 Intercompany Hospital Tables and the 1956 Intercompany Surgical Tables, (incorporated herein by reference).

(2) For contracts issued on or after January 1, 1986: The 1974 Medical Expense Tables, (incorporated herein by reference).

ii. When calculating claim reserves use: No specific standard. See (a)5 below.

3. For cancer expense benefits (scheduled benefits or fixed time period benefits only):

i. When calculating contract reserves use:

(1) For contracts issued on or after January 1, 2001, and, at the option of the insurer, contracts issued on or after January 1, 1986: The 1985 NAIC Cancer Claim Cost Tables, (incorporated herein by reference).

ii. When calculating claim reserves use: No specific standard. See (f) below.

4. For accidental death benefits:

i. When calculating contract reserves use:

(1) On contracts issued on or after January 1, 1966: The 1959 Accidental Death Benefits Table, (incorporated herein by reference).

ii. When calculating claim reserves use the actual amount incurred.

5. For other individual contract benefits.

i. When calculating contract reserves for all other individual contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

ii. When calculating claim reserves for all benefits other than disability, claim reserves are to be determined as provided in the standards.

R.1984 d.512, eff. November 5, 1984.
See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

11:4–6.15 Specific standards for morbidity for valuation of specified group contract health insurance benefits

(a) Minimum morbidity standards for valuation of specified group contract health insurance benefits are as follows:

1. For disability income benefits due to accident or sickness use:

i. When calculating contract reserves:

(1) For contracts issued prior to January 1, 2001: The same basis, if any, as that employed by the insurer as of January 1, 2001;

(2) For contracts issued on or after January 1, 2001: The 1987 Commissioners Group Disability Income Table (87CGDT), (incorporated herein by reference).

ii. When calculating claim reserves use:

(1) For claims incurred on or after January 1, 2001: The 1987 Commissioners Group Disability Income Table (87CGDT);

(2) For claims incurred prior to January 1, 2001: Use of the 87CGDT is optional.

2. For other group contract benefits:

i. When calculating contract reserves: For all other group contract benefits, morbidity assumptions are to be determined as provided in the reserve standards.

ii. When calculating claim reserves: For all benefits other than disability, claim reserves are to be determined as provided in the standards.

11:4–6.16 Specific standards for interest

(a) For contract reserves the maximum interest rate is:

1. For contracts issued prior to January 1, 1973: 3½ percent.

2. For contracts issued on or after January 1, 1973 through December 31, 2000: A rate of interest not exceeding the maximum rate of interest specified in N.J.S.A. 17B:19–8 for policies of life insurance which are issued the same year and, if relevant, for policies of life insurance containing a maximum guaranteed duration of more than 10 years but not more than 20 years.

3. For contracts issued on or after January 1, 2001: The maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the health insurance contract.

(b) For claim reserves on policies that require contract reserves where the claim incurral date is prior to January 1, 2001, the maximum rate of interest is:

1. For contracts issued prior to January 1, 1973: 3½ percent.

2. For contracts issued on or after January 1, 1973 through December 31, 2000: A rate of interest not exceeding the maximum rate of interest specified in N.J.S.A. 17B:19–8 for policies of life insurance which are issued the same year and, if relevant, for policies of life insurance containing a maximum guaranteed duration of more than 10 years but not more than 20 years.

3. Upon demonstrating the adequacy of the reserves and with the approval of the Commissioner, a company may determine the maximum interest rate to be used in calculating the claim reserve using the rates specified in (b)1 and 2 above, based on the incurral date of the claim instead of the contract issue date. Once an insurer elects to calculate reserves based on the incurral date of the claim, all future valuations must be on that basis.

(c) For claim reserves on policies that require contract reserves, where the claim incurral date is on or after January 1, 2001, the maximum rate of interest is the maximum rate permitted by law in the valuation of whole life insurance issued on the same date as the claim incurral date.

(d) For claim reserves on policies not requiring contract reserves, where the claims incurral date is prior to January 1, 2001, the maximum rate of interest is:

1. For contracts issued prior to January 1, 1973: 3½ percent.

2. For contracts issued on or after January 1, 1973 through December 31, 2000: A rate of interest not exceeding the maximum rate of interest specified in N.J.S.A. 17B:19–8 for policies of life insurance which are issued the same year and, if relevant, for policies of life insurance containing a maximum guaranteed duration of more than 10 years but not more than 20 years.

3. Upon demonstrating the adequacy of the reserves and with the approval of the Commissioner, a company may determine the maximum interest rate to be used in calculating the claim reserve using the rates specified in (d)1 and 2 above, based on the incurral date of the claim instead of the contract issue date. Once an insurer elects to calculate reserves based on the incurral date of the claim, all future valuations must be on that basis.

(e) For claim reserves on policies not requiring contract reserves, where the claim incurral date is on or after January 1, 2001, the maximum rate of interest is the maximum rate permitted by law in the valuation of single premium immediate annuities issued on the same date as the claim incurral date, reduced by one hundred basis points. Upon demonstrating the adequacy of the reserves and with the prior approval of the Commissioner, an insurer may elect to use this rate for claims incurred prior to January 1, 2001. Once an insurer makes such an election, all future valuations must be on that basis.

11:4–6.17 Specific standards for mortality

The mortality basis used for all policies except long-term care individual policies and group certificates and for long-term care individual policies or group certificates issued before January 1, 2001 shall be according to a table (but without use of selection factors) permitted by law for the valuation of whole life insurance issued on the same date as the health insurance contract. For long-term care insurance individual policies or group certificates issued on or after January 1, 2001 the mortality basis used shall be the 1983 Group Annuity Mortality Table, incorporated herein by reference, without projection.

11:4–6.18 Reserves for waiver of premium

(a) Where an insurer calculates tabular reserves using the 1964 CDT, 85CIDA, 85CIDB or any other table based on exposures that include contracts on premium waiver as in-force contracts rather than a table based on "active lives," reserves shall be valued on the following basis:

1. Claim reserves shall include reserves for premiums expected to be waived, valuing as a minimum the valuation net premium being waived.

2. Premium reserves shall include contracts on premium waiver as in-force contracts, valuing as a minimum the unearned modal valuation net premium being waived.

3. Contract reserves shall include recognition of the waiver of premium benefit in addition to other contract benefits provided for, valuing as a minimum the valuation net premium to be waived.

(b) If an insurer is valuing reserves on a true "active life" table, or if a specific valuation table is not being used, but the insurer's gross premiums are calculated on a basis that includes in the projected exposure only those contracts for which premiums are being paid, it may not be necessary to provide specifically for waiver of premium reserves. Any insurer using such a true "active life" basis shall consider whether or not additional liability should be recognized on account of premiums waived during periods of disability or during claim continuation.

SUBCHAPTER 7. PROCEDURE FOR THE REGULATION OF CONSENT TO HIGHER RATE FILINGS

11:4–7.1 Filing requirements

(a) Every application must be filed with the Commissioner of the Department of Banking and Insurance within 20 work days after the insured has signed it or within 20 work days of the inception date of the policy, whichever is earlier.

(b) Each application shall show the following information:

1. Name and address of company, and signature by authorized company representative;

Name, address, New Jersey license number and signature of producer;

3. Name and address of insured;

4. Effective date and expiration date of policy;

5. Policy number, if available;

6. Coverages applied for, including limits, amounts of insurance, deductibles, and so forth;

7. Exposure identification class, territory, description and use of automobile, and so forth;

8. Premiums:

i. The premium developed by the rating system approved for the company for the coverages applied for, identified as "Normal Premium";

ii. The additional premium to be charged in consideration of the additional hazard, identified as "Additional Premium";

iii. The total of the two amounts identified as "Premium Payable".

9. Underwriting information in support of the additional premium under (a)8ii above. In the case of automobile insurance, liability and physical damage, a copy of the abstract of driving record from the Division of Motor Vehicles shall be submitted. Such abstract is not required if the coverage applied for is excess coverage over the coverages and limits available under any residual market mechanism providing automobile insurance pursuant to statute. In the case of fire insurance, an inspection report, based upon an inspection performed by a qualified person, shall be submitted.

10. Each application shall be signed by the insured and it shall contain the following statement:

"I consent to the premium shown as 'Premium Payable' on this application which is higher than would normally apply because of the greater hazard involved."

11. The application form shall contain the following statement signed by the producer of record (broker or agent) or by an officer of the company providing the coverage:

"Under penalty of N.J.S.A. 17:29A–16 and N.J.S.A. 17:29A–22, I declare that this application was fully completed as shown, before signed by the applicant."

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).
In (b): deleted "New Jersey Automobile Insurance Plan" and added text regarding "any residual market mechanism."
Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

11:4–7.2 Premium charges

(a) Premium charges in excess of those produced by the rating system approved for the submitting company shall be reasonable and adequate and not unfairly discriminatory, and shall be proportionate to the additional hazard, subject to the following provisions on business for which coverage is available under any residual market mechanism created by statute:

1. Insurance available from these plans shall be rated in accordance with the rating systems approved for these facilities and the procedures applicable to such business shall be followed, if written under the Consent to Higher Rate provision. Any surcharges to be applied to such business must be documented by any required inspection report.

2. An insured qualifying for coverage under these plans shall not be offered coverage at lower limits, lower amounts or otherwise reduced coverage except at a proportionate reduction in the otherwise applicable premium.

3. If an insured eligible for insurance from these plans requests limits or amounts of insurance higher than available thereunder, the excess portion may be written at rates higher than produced by the company's rating system, subject to the standards set forth above.

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).
In (a): deleted "New Jersey Automobile Insurance Plan" and added text regarding "any residual market mechanism..."
In (a)1: deleted text defining documentation by motor vehicle reports for automobile insurance and reference to cases of fire and crime insurance.
Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

11:4–7.3 Approval of applications

(a) Applications complying with the above rules will be approved by the Commissioner of the Department of Banking and Insurance on a current basis and the submitting carrier can expect to be notified promptly of such action.

(b) Applications that fail to comply with any of the above requirements or do not meet the requirement of being reasonable and adequate and not unfairly discriminatory will be disapproved. Notification of such disapproval will be sent by the Commissioner to the company, the producer of record and the insured.

(c) The company and the insured shall have the same legal remedies as are available in the case of disapproval of any rate filing.

(d) If a filing is disapproved, the policy with respect to which the filing had been made may be cancelled by the company on the basis of the premium that is applicable under the rating system approved for the company (normal premium), but such cancellations must be on a *pro rata* basis. However, if a disapproval is sustained upon an appeal by the insured, cancellation shall be *pro rata* on the basis of the "premium payable" as defined above.

(e) If the company wishes to continue the policy in force after the "consent to rate" filing has been disapproved, it may do so by charging the normal premium as of the policy's inception date.

(f) Nothing in this regulation shall prevent a company from filing a rate that produces a premium lower than that

produced by the approved rating system, including the rating systems applicable under any residual market mechanism created by statute.

Amended by R.1991 d.3, effective January 7, 1991.
See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).
In (f): deleted text regarding "New Jersey Automobile Insurance Plan" and added reference to "... any residual market ... but not limited to."
Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

SUBCHAPTER 8. CHARITABLE ANNUITIES

11:4–8.1 Purpose

(a) N.J.S.A. 17B:17–13.1 provides that qualified organizations as defined therein may enter into annuity agreements under conditions which are different from those which are applicable to organizations which are deemed to be insurers. This subchapter protects the interest of individual holders of annuities and their beneficiaries by requiring:

1. The use of forms which clearly set forth the conditions of the agreement being entered into;

2. The maintenance of segregated assets in such form and such amount as will protect the interest of the annuitants; and

3. The submission to the Commissioner, by the issuers of charitable annuities, of periodic reports which will enable the Commissioner to determine that the requirements of law and of this subchapter are being met.

(b) Charitable annuities are different from other annuities in that a significant part of the consideration paid for the annuity represents a gift to the issuing organization. In order to assure that such a gift results, this subchapter specifies maximum rates of income to annuitants for charitable annuities.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Deleted text in subsection (a).

11:4–8.2 Definitions

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

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

"Deferred annuity" means an annuity where the first annuity payment is due no earlier than one year from the issue date of the contract, and the annuity is not an immediate annuity.

"Immediate annuity" means an annuity where the first annuity payment is due not more than 13 months from the issue date of the contract.

"Reserves" means the liability established to assure that future annuity benefits can be paid.

"Surplus" means the excess of admitted assets over liabilities.

Repeal and New Rule, R.2005 d.49, effective February 7, 2005.
See: 36 N.J.R. 4623(a), 37 N.J.R. 528(a).
Section was "Forms of agreement".

11:4–8.3 Application for a special permit

(a) A qualified organization proposing to enter into an annuity agreement pursuant to N.J.S.A. 17B:17–13.1 shall first apply to the Commissioner for approval as a special permit holder. The application shall be in a form prescribed by the Commissioner. An application shall include, but not be limited to, the following:

1. A completed application form;

2. Organizational documents, including the articles of incorporation or articles of association and bylaws;

3. The applicant's organizational chart, which shall identify the parent organization, and all subsidiaries and affiliates of the applicant;

4. The applicant's or, where not available, the applicant's parent organization's, most recent audited financial statements and the Independent Auditors Report;

5. Documentation from the Internal Revenue Service that the applicant is exempt from Federal income tax pursuant to Section 501(c)(3) of the Internal Revenue Code;

6. The most recent Internal Revenue Form 990 and/or any other annual submissions that the Internal Revenue Service may require because of the applicant's tax exempt status;

7. Documentation that the applicant is registered and current with the New Jersey Department of the Treasury as a domestic or foreign entity authorized to do business in New Jersey;

8. A copy of the Letter of Registration or the Letter of Exemption issued to the applicant by the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, Charities Registration Section;

9. Evidence that the applicant has been in active operation for at least 10 years pursuant to N.J.S.A. 17B:17–13.1a;

10. Identification of any planned giving organization of which the applicant is a member;

11. The board resolution requiring the segregation of assets for annuity benefits;

(c) The Commissioner may consider that each corporation or association in a group of two or more corporations and/or associations which has met all other requirements of this section has met the requirements as to the amount of segregated annuity fund assets, provided:

1. The segregated assets of each such organization shall equal at least 110 per cent of the sum of the reserves on its outstanding agreements calculated in accordance with the provisions of N.J.S.A. 17B:19;

2. The combined segregated assets of all such organizations, when considered as a unit, meet the requirements of this section concerning the amount of segregated assets;

3. The organizations enter into an agreement by which each organization pledges the full amount of its segregated annuity assets as liable for the payment of each annuity and all annuities issued under the agreement by each organization and all organizations in the group;

4. Such agreement shall be determined by the Commissioner to protect the public at least to the same extent as though all annuities were issued by a single organization;

5. No change may be made in such agreement and no organization may be added to or released from such agreement without the prior approval of the Commissioner; and

6. The Commissioner may require that, in addition to any other reports that he shall normally require from permit holders, the group of organizations file annually a consolidated report in order to demonstrate that the requirements of this section are met on a consolidated basis.

(d) Each member organization within the group will be subject to all requirements of the law and of this subchapter other than the requirement of $100,000 minimum surplus; this minimum must be satisfied by the group, however.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added "N.J.S.A. 17B–19".
Recodified from N.J.A.C. 11:4–8.4 by R.2005 d.49, effective February 7, 2005.
See: 36 N.J.R. 4623(a), 37 N.J.R. 528(a).
Former N.J.A.C. 11:4–8.6, Annual report, recodified to N.J.A.C. 11:4–8.8.

11:4–8.7 Compliance with investment requirements

(a) The segregated assets held by a special permit holder shall be invested pursuant to the standards set forth at N.J.S.A. 3B:20–11.1 et seq. An application for a special permit shall include the applicant's plan of operation for the segregated account. The plan of operation shall include, but not be limited to, the following:

1. A statement of the amount of the gift to be placed in the segregated account. If such amount is less than the entire gift, the method for determining such amount;

2. Standards for monitoring the adequacy of the segregated account to meet the requirements of N.J.A.C. 11:4–8.6 on a continuous basis;

3. A contingency plan for additional sources of funding if the segregated account falls below the statutorily required minimum amount; and

4. An investment plan for the segregated account, which shall include:

i. The person(s) responsible for oversight of the investments, and whether such responsibility is to be delegated;

ii. The allocation of assets by investment categories;

iii. The standards for investment quality; and

iv. The duration and liquidity of assets.

(b) Any proposed change(s) to a plan of operation of the segregated account, or to the investment plan of the segregated account, shall not be implemented unless the special permit holder has filed the changes with the Commissioner at least 30 days prior to the intended date of implementation, and the Commissioner has not disapproved the changes within that 30–day period. The proposed change(s) shall be submitted to:

Office of Life and Health
Attention: Charitable Annuity Review
NJ Department of Banking and Insurance
PO Box 325
Trenton, NJ 08625–0325

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added "N.J.S.A. 17B–20". Deleted text "However, prior to ... chapter 19 of the code."
Recodified from N.J.A.C. 11:4–8.5 and amended by R.2005 d.49, effective February 7, 2005.
See: 36 N.J.R. 4623(a), 37 N.J.R. 528(a).
Rewrote the section. Former N.J.A.C. 11:4–8.7, Special permit, repealed.

11:4–8.8 Annual report

(a) As of December 31 of the calendar year in which a special permit is issued, and as of December 31 of each succeeding calendar year, the holder of a special permit shall submit a report to the Commissioner. Such report shall be submitted to the Commissioner within 120 days following the end of the calendar year to which the report applies. The annual report shall be in such form as the Commissioner shall prescribe within three months prior to the end of each preceding calendar year. Subject to approval by the Commissioner, a special permit holder may file its annual report on a fiscal year basis.

(b) Each special permit holder shall submit, as part of the annual report, a statement by a qualified actuary setting forth his or her opinion as to the adequacy of reserves. A qualified actuary for the purpose of this subsection means a member in good standing of the American Academy of Actuaries, or a person who has otherwise demonstrated his or her actuarial competence to the satisfaction of the Commissioner. The Commissioner shall waive the requirement for the actuarial opinion if a special permit holder demonstrates to the satisfaction of the Commissioner that it has the appropriate software and technical expertise to calculate the required reserves, and that waiving this requirement would not be hazardous to the operations of the segregated account.

(c) Each special permit holder shall submit a copy of the workpapers used to calculate the required reserves.

(d) Each special permit holder shall respond on a timely basis to any inquiry of the Commissioner, or his designee, regarding the annual report.

(e) Each special permit holder shall submit, with the annual report of the segregated account required in (a) above, a copy of the applicant's or, where not available, the applicant's parent organization's, most recent audited financial statements and the Independent Auditors Report.

Amended by R.1985 d.94, effective March 4, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Added (b)-(d).
Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
In (a), added the last sentence; rewrote (b) and (c); and added (e).
Recodified from N.J.A.C. 11:4–8.6 and amended by R.2005 d.49, effective February 7, 2005.
See: 36 N.J.R. 4623(a), 37 N.J.R. 528(a).
Rewrote (e). Former N.J.A.C. 11:4–8.8, Separability of provisions, recodified to N.J.A.C. 11:4–8.10.

11:4–8.9 Effect on previously filed forms

Forms previously filed or approved by the Commissioner pursuant to N.J.S.A. 17B:17–13.1 that are not in compliance with this subchapter shall be refiled with the annual report for calendar year 2004 or the first fiscal year ending after December 31, 2004.

New Rule, R.2005 d.49, effective February 7, 2005.
See: 36 N.J.R. 4623(a), 37 N.J.R. 528(a).
Former N.J.A.C. 11:4–8.9, Penalties, recodified to N.J.A.C. 11:4–8.11.

11:4–8.10 Separability of provisions

If any provision of this subchapter or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect the provisions or applications of this subchapter which can be given effect without the invalid provision or application, and for this purpose the provisions of the subchapter are separable.

Amended by R.1985 d.94, effective March 18, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Deleted "regulation" and substituted "subchapter".
Recodified from N.J.A.C. 11:4–8.8 by R.2005 d.49, effective February 7, 2005.
See: 36 N.J.R. 4623(a), 37 N.J.R. 528(a).

11:4–8.11 Penalties

Failure to comply with the provisions of this subchapter will subject any special permit holder to the penalties provided by N.J.S.A. 17B:17–13.1d and any other penalties available to the Commissioner.

Amended by R.1985 d.94, effective March 18, 1985.
See: 16 N.J.R. 3172(a), 17 N.J.R. 598(b).
Deleted "Effective date" rule and substituted "Penalties".
Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Recodified from N.J.A.C. 11:4–8.9 by R.2005 d.49, effective February 7, 2005.
See: 36 N.J.R. 4623(a), 37 N.J.R. 528(a).

SUBCHAPTER 9. PERSONAL LINES INSURANCE: PROSPECTIVE LOSS COSTS FILING PROCEDURES

11:4–9.1 Purpose and scope

(a) This subchapter establishes data requirements and filing procedures for participating insurers in rating organizations to adopt or modify a rating organization's approved prospective loss costs.

(b) This subchapter applies to all rating organizations which file prospective loss costs and all insurer filings which adopt or modify a rating organization's prospective loss cost filing for personal lines property/liability insurance made pursuant to N.J.S.A. 17:29A–1 et seq. This does not apply to private passenger automobile insurance rate filings for which the use of rating organizations are specifically prohibited by N.J.S.A. 17:33B–31.

(c) All filings made pursuant to this subchapter shall be made in accordance with N.J.S.A. 17:29A–1 et seq., N.J.A.C. 11:1–2 and 11:1–32.

11:4–9.2 Definitions

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

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

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

"Expenses" means that portion of a rate attributable to commissions and brokerage, other acquisition expenses, general expenses, taxes, licenses, and fees.

"Loss costs multiplier" means the adjustment reflecting expenses, profit loading and any modifications that the insurer uses on the loss costs to produce final rates.

"Minimum premium" means the smallest amount of premium for which an insurer will issue coverage under a given policy.

"Prospective loss costs" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

"Rate" means the unit charge by which the measure of exposure or the amount of insurance specified in a policy of insurance or covered thereunder is multiplied to determine the premium. The unit charge may be expressed as a single number or as a prospective loss cost and an adjustment to account for the treatment of expenses, profit and variations in loss experience.

"Rating organization" means every person or persons, corporation, partnership, company, society, or association engaged in the business of ratemaking for two or more insurers.

"Supplementary rate information" means any manual or plan of rates, statistical plan, classification, rating schedule, rating rule and any other rule used by an insurer in making rates. This includes policy-writing rules, rating plans, territory codes and descriptions, and rules which include factors or relativities such as increased limits factors, classification relativities or similar factors used to determine the rate in effect or to be in effect.

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

11:4–9.3 Prospective loss cost filing requirements for rating organizations

(a) A rating organization that desires to file prospective loss costs with the Commissioner shall develop a filing containing advisory prospective loss costs and supporting actuarial and statistical data.

(b) Rating organizations that file advisory prospective loss cost filings with the Commissioner shall:

1. Submit a filing that contains the advisory prospective loss costs and the underlying loss data and other supporting actuarial information for any calculations or assumptions underlying those loss costs. Filings of prospective loss costs shall be filed and become effective in accordance with N.J.S.A. 17:29A–1 et seq. and N.J.A.C. 11:1–2; and

2. No longer develop or file minimum premiums with the filing of prospective loss costs.

(c) A rating organization shall provide the Department with printed manuals of prospective loss costs, as well as rules and other supplementary rating information filed and approved pursuant to N.J.S.A. 17:29A–1 et seq., and may provide this information to its member/subscriber insurers upon request.

(d) Rating organizations shall continue to develop and file rules, relativities and other supplementary rate information on behalf of their member/subscriber insurers.

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Rewrote (c).

11:4–9.4 Prospective loss costs filing requirements for insurers

(a) In order for an insurer to incorporate a rating organization's approved prospective loss costs to establish its own rates, an insurer shall:

1. Be a participating insurer in the rating organization; and

2. File its loss costs multiplier using the Filing Adoption Form (as set forth in Appendix A to this subchapter and incorporated herein by reference). An insurer's loss costs multiplier shall be filed and become effective in accordance with N.J.S.A. 17:29A–1 et seq. and N.J.A.C. 11:1–2. An insurer's final rates shall be a combination of the approved prospective loss costs and the approved loss costs multiplier.

i. An insurer may file modifications to the rating organization's approved prospective loss costs filing based on its own anticipated experience by using the Filing Adoption Form. Supporting documentation shall be filed for any modification (upwards or downwards) to the rating organization's prospective loss cost filings.

ii. An insurer's approved loss costs multiplier shall remain in effect until the insurer withdraws the multiplier or until a revised Filing Adoption Form is filed by the insurer and approved by the Department.

(b) An insurer may vary expense loads by individual lines, sublines or classifications of insurance. An insurer may use variable or fixed expense loads or a combination of these to establish its expense loadings by using the Filing Adoption Form, items 17–21.

1. An insurer's loss cost multiplier based on its expenses plus any profit provision shall not include the automobile insurance surtax pursuant to N.J.S.A. 17:33B–49, the Property–Liability Insurance Guaranty Association's assessments on private passenger automobiles pursuant to N.J.S.A. 17:30A–8a(9), and recoupment of paid apportioned shares of Market Transition Facility losses and expenses pursuant to N.J.S.A. 17:33B–11d.

2. An insurer shall provide documentation to support its profit loading, which shall demonstrate how the insurer reflects investment income.

3. An insurer shall provide the overall dollar impact and the number of New Jersey policies affected by the filing.

(c) Any participating insurer of a rating organization shall continue to use all rates and deviations currently in effect for its use until disapproved pursuant to N.J.S.A. 17:29A–14 or until the insurer revises its rates, either upon approval of an independent filing or upon approval of a Filing Adoption Form.

(d) Once an insurer has an approved loss costs multiplier on file with the Department, such multiplier shall be deemed to be automatically applicable to subsequent rating organization prospective loss costs filings, subject to the following requirements:

1. An insurer which intends to use a subsequent revision of approved prospective loss costs and the effective date of the rating organization shall not file anything unless final printed rate pages were previously submitted. If final printed rate pages were previously submitted, then new rate pages shall then be submitted to reflect the revision;

2. An insurer, which intends to use a subsequent revision of approved prospective loss costs but with a different effective date, shall file with the Department its proposed effective date before the effective date of the rating organization's prospective loss costs;

3. An insurer which intends to use a subsequent revision of approved prospective loss costs and to change its loss costs multiplier shall file a revised Filing Adoption Form for approval in accordance with N.J.S.A. 17:29A–1 et seq. and N.J.A.C. 11:1–2 before the effective date of the rating organization's prospective loss costs filing; and

4. An insurer, which does not intend to use a subsequent revision of approved prospective loss costs, shall notify the Department before the effective date of the rating organization's prospective loss costs filing. The insurer shall file a Non–Adoption of Prospective Loss Cost Form (as set forth in Appendix B to this subchapter and incorporated herein by reference) with the Department.

(e) When filing to adopt a rating organization's prospective loss cost filing, the insurer shall also file with the Department, within 30 days of the effective date of the insurer's rates, either:

1. A final printed manual page indicating the loss cost multiplier to be applied to the rating organization's prospective loss costs, including its effective date; or

2. Final printed manual pages indicating the final rates developed by application of the loss cost multiplier to the rating organization's loss costs, including the effective date.

11:4–9.5 Penalties

Rating organizations and insurers which fail to comply with the filing submission requirements of this subchapter shall be subject to penalties as provided by law.

APPENDIX A

Space Reserved for Insurance Department Use

Date of filling out Form: _____

NEW JERSEY INSURER RATE FILING
ADOPTION OF ADVISORY ORGANIZATION
PROSPECTIVE LOSS COSTS
FILING ADOPTION FORM

1. INSURER NAME _____
   ADDRESS _____
   _____
   _____
   _____
   _____
   PERSON RESPONSIBLE FOR FILING _____
   TITLE _____ TELEPHONE # _____

2. INSURER GROUP NAIC # _____

2A. INSURER COMPANY NAIC# _____

3. LINE OF INSURANCE _____

4. ADVISORY ORGANIZATION _____

5. ADVISORY ORGANIZATION REFERENCE FILING # _____

6. The above insurer hereby declares that it is a member, subscriber or service purchaser of the named advisory organization for this line of insurance. The insurer hereby files to be deemed to have independently submitted as its own filing the prospective loss costs in the captioned Reference Filing.

   The insurer's rates will be the combination of the prospective loss costs and the loss cost multipliers.

7. PROPOSED RATE LEVEL CHANGE _____% EFFECTIVE DATE_____

8. PRIOR RATE LEVEL CHANGE _____% EFFECTIVE DATE_____

9. ATTACH "FILING ADOPTION FORM" FOR EACH INSURER *IF SELECTED LOSS COST MULTIPLIER IS DIFFERENT.*

** The Filed Loss Cost Level Change Factor for the initial filing is the Ratio of Revised Loss Costs to Current Rates divided by the Deviation which the insurer applied to the Current Rates (expressed as a decimal); and for subsequent filings, the Ratio Loss Cost Level to Current Loss Cost Levels.

APPENDIX B

NEW JERSEY FORM NA—1

NON-ADOPTION OF PROSPECTIVE LOSS COST

1. Insurer: _____ NAIC#: _____

2. Rating Organization Affiliation: _____

3. Line of Insurance: _____

4. Rating Organization Designation Number: _____

5. Effective Date of Non-Adoption: _____

6. Rating Organization Designation Number Currently Being Used: _____

7. Effective Date of Use: _____

SUBCHAPTER 10. (RESERVED)

SUBCHAPTER 11. LIFE INSURANCE SOLICITATION

11:4–11.1 Purpose

(a) The purpose of this regulation is to require insurers to deliver to purchasers of life insurance, information which will improve the buyer's ability to select the most appropriate plan of life insurance for his needs, improve the buyer's understanding of the basic features of the policy which has been purchased or which is under consideration and improve the ability of the buyer to evaluate the relative costs of similar plans of life insurance.

(b) This regulation does not prohibit the use of additional material which is not in violation of this regulation or any other New Jersey statute or regulation.

Recodified from N.J.A.C. 11:4–11.2 by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Former N.J.A.C. 11:4–11.1, Authority, was repealed.

11:4–11.2 Scope

(a) Except as hereafter exempted, this regulation shall apply to any solicitation, negotiation or procurement of life insurance occurring within this State. This regulation shall apply to any issuer of life insurance contracts.

(b) Unless otherwise specifically included, this regulation shall not apply to:

1. Annuities;

2. Credit life insurance;

3. Group life insurance;

4. Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA);

5. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

Recodified from N.J.A.C. 11:4–11.3 by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Former N.J.A.C. 11:4–11.2, Purpose, was recodified to N.J.A.C. 11:4–11.1.

11:4–11.3 Definitions

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

"Buyer's guide" means a document which contains, and is limited to, the language contained in this appendix to this subchapter or language approved by the Commissioner of Banking and Insurance.

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

"Equivalent level annual dividend" means that amount which is calculated by applying the following steps:

1. Accumulate the annual cash dividends at five per cent interest compounded annually to the end of the tenth and 20th policy years;

2. Divide each accumulation of step 1 by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in step 1 over the respective periods stipulated in step 1. If the period is ten years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;

3. Divide the results of step 2 by the number of thousands of the equivalent level death benefit to arrive at the equivalent level annual dividend.

"Equivalent level death benefit of a policy or term life insurance rider" means an amount calculated as follows:

1. Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for ten and 20 years at five per cent interest compounded annually to the end of the tenth and 20th policy years respectively;

2. Divide each accumulation of step 1 above by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in step 1 over the respective periods stipulated in step 1. If the period is ten years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;

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

"Life insurance cost indexes" means the following:

1. "Life insurance surrender cost index" is calculated by applying the following steps:

i. Determine the guaranteed cash surrender value, if any, available at the end of the tenth and 20th policy years;

ii. For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual cash dividends at five per cent interest compounded annually to the end of the period selected and add this sum to the amount determined in subparagraph i of this paragraph;

iii. Divide the result obtained in subparagraph ii above (subparagraph i for guaranteed-cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subparagraph ii (subparagraph i for guaranteed-cost policies) over the respective periods stipulated in subparagraph i. If the period is ten years, the factor is 13.207 and if the period is 20 years, the factor is 34.719;

iv. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at five per cent interest compounded annually to the end of the period stipulated in subparagraph i and dividing the result by the respective factors stated in subparagraph iii (this amount is the annual premium payable for a level premium plan);

v. Subtract the result of subparagraph iii from subparagraph iv;

vi. Divide the result of subparagraph v by the number of thousands of the equivalent level death benefit to arrive at the life insurance surrender cost index.

2. "Life insurance net payment cost index" is calculated in the same manner as the comparable life insurance cost index except that the cash surrender value and any terminal dividend are set at zero.

"Policy summary", for the purposes of these rules, means a written statement describing the elements of the policy, including but not limited to:

1. A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION;

2. The name and address of the insurance agent, or, if no agent is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary;

3. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written;

4. The generic name of the basic policy and each rider;

5. The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including, but not necessarily limited to, the years for which life insurance cost indexes are displayed and at least one age from 60 through 65 or maturity whichever is earlier:

i. The annual premium for the basic policy;

ii. The annual premium for each optional rider;

iii. Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide, or other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;

iv. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;

v. Cash dividends payable at the end of the year with value shown separately for the basic policy and each rider (Dividends need not be displayed beyond the 20th policy year);

vi. Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above;

6. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the policy summary includes the maximum annual percentage rate;

7. Life insurance cost indexes for ten and 20 years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders, which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits, nor for basic policies or optional riders covering more than one life;

8. The equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance costs indexes are displayed;

9. A policy summary which includes dividends shall also include a statement that dividends are based on the company's current dividend scale and are not guaranteed, in addition to a statement in close proximity to the equivalent level annual dividend as follows: An explanation of the intended use of the equivalent level annual dividend is included in the life insurance buyer's guide;

10. A statement in close proximity to the life insurance cost indexes as follows: An explanation of the intended use of these indexes is provided in the life insurance buyer's guide;

11. The date on which the policy summary is prepared.

Note: The policy summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as to not minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in paragraph 5 of this subsection shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or each class of insureds if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

Recodified from N.J.A.C. 11:4–11.4 and amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Former N.J.A.C. 11:4–11.3, Scope, recodified to N.J.A.C. 11:4–11.2.

11:4–11.4 Disclosure requirements

(a) The insurer shall provide, to all prospective purchasers, a buyer's guide and a policy summary at least seven days prior to accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the policy summary contains such an unconditional refund offer, in which event the buyer's guide and policy summary must be delivered with the policy or prior to delivery of the policy.

(b) The insurer shall provide a buyer's guide and a policy summary to any prospective purchaser upon request.

(c) In the case of policies whose equivalent level death benefit does not exceed $5,000, the requirement for providing a policy summary will be satisfied by delivery of a written statement containing the information described in N.J.A.C. 11:4–11.4(g)2 through 7, 10 and 11.

(d) In the case of policies whose equivalent level death benefit is less than $2,000, the provision of a policy summary and a buyer's guide will be optional for the insurer.

(e) For in-force premium-paying policies, policy holders shall have the right to obtain a Policy Summary at cost. The company may charge a reasonable fee for preparing this summary, not to exceed $5.00, and may utilize reasonable assumptions in providing the cost disclosure information, so long as they are clearly disclosed. In calculating cost indexes on policy anniversaries 10 and 20 years from the date of request, the initial cash value, defined as the cash value of the policy (exclusive of policy loans and the value of dividend accumulations or dividend additions but including any terminal dividend) on the policy anniversary at the beginning of the period for which the indexes are calculated, should be reflected as follows:

1. The "equivalent level death benefit" defined in N.J.A.C. 11:4–11.4 is reduced by the amount of the initial cash value;

2. The "guaranteed cash surrender value" determined in N.J.A.C. 11:4–11.4 is reduced by the amount of the initial cash value; and

3. The "equivalent level premium" determined in N.J.A.C. 11:4–11.4 is increased by 4.7619 percent of the amount of the initial cash value.

As amended, R.1982 d.17, eff. February 1, 1982 (Operative June 1, 1982).
See: 13 N.J.R. 36(a), 14 N.J.R. 159(a).
(e) added.

Recodified from N.J.A.C. 11:4–11.5 by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Former N.J.A.C. 11:4–11.4, Definitions, recodified to N.J.A.C. 11:4–11.3.

11:4–11.5 General provisions

(a) Each insurer shall maintain at its home office or principal office, a complete file containing one copy of each document authorized by the insurer for use pursuant to this regulation. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use.

(b) An agent shall inform the prospective purchaser, prior to commencing a life insurance sales presentation, that he is acting as a life insurance agent and inform the prospective purchaser of the full name of the insurance company which he is representing to the buyer. In sales situations in which an agent is not involved, the insurer shall identify its full name.

(c) Terms such as estate planner, financial planner, investment advisor, financial consultant, or financial counseling shall not be used in such a way as to imply that the insurance agent is generally engaged in an advisory business in which compensation is unrelated to sale unless such is actually the case.

(d) Any reference to policy dividends must include a statement that dividends are not guaranteed.

(e) A system or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such a system may be used for the purpose of demonstrating the cash-flow pattern of a policy if such presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.

(f) A presentation of benefits shall not display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately in close proximity thereto.

(g) A statement regarding the use of the life insurance cost indexes shall include an explanation to the effect that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

(h) A life insurance cost index which reflects dividends or an equivalent level annual dividend shall be accompanied by a statement that it is based on the company's current dividend scale and is not guaranteed.

(i) For the purposes of this regulation, the annual premium for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

(j) All sales proposals and sales presentations of individual life insurance products which fail to fully and fairly inform an applicant or prospective insured as to future premium changes, benefits and related options constitute a misrepresentation as to material facts.

(k) With respect to life insurance products which require an additional first year premium, for which there are no comparable additional first year insurance benefits, and which also contain partial endowment benefits or their cash value equivalent, any statement or illustration in any advertisement, sales material, or sales presentation which uses such terms as "deposit," "accumulation," "interest at x percent," "double your money" and similar terms associated with fund accumulations and investment contracts is prohibited unless the insurer can demonstrate that all major characteristics customarily associated with such contracts are present; the name given to such products shall not include any term that implies a "deposit" or any similar term; and no statement may be made or implied which purports to show that the partial endowment or cash value equivalent arises solely from the additional first year premium.

(*l*) If the policy contains a provision permitting the making of voluntary deposits which will accumulate at interest, the nature thereof shall be disclosed, and such disclosure shall distinguish such deposit provision and the insured's rights thereunder from any other premiums for the basic policy and riders.

As amended, R.1982 d.17, eff. September 1, 1982 (operative June 1, 1982).
See: 13 N.J.R. 36(a), 14 N.J.R. 159(a).
(j), (k) and (*l*) added.
Recodified from N.J.A.C. 11:4–11.6 by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Former N.J.A.C. 11:4–11.5, Disclosure requirements, recodified to N.J.A.C. 11:4–11.4.

11:4–11.6 Failure to comply

Failure of an insurer to provide or deliver a buyer's guide or a policy summary as provided in N.J.A.C. 11:4–11.5, shall constitute an omission which misrepresents the benefits, advantages, conditions or terms of an insurance policy.

Recodified from N.J.A.C. 11:4–11.7 by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Former N.J.A.C. 11:4–11.6, General provisions, recodified to N.J.A.C. 11:4–11.5.

11:4–11.7 Effective date

With respect to the buyer's guide, this rule shall apply to all solicitations of life insurance which commence on or after February 1, 1977; otherwise, this rule shall apply to all solicitations of life insurance which commence on or after January 1, 1978.

As amended, R.1977 d.187, eff. May 25, 1977.
See: 9 N.J.R. 283(a).
Recodified from N.J.A.C. 11:4–11.8 by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Former N.J.A.C. 11:4–11.7, Failure to comply, recodified to N.J.A.C. 11:4–11.6.

11:4–11.8 (Reserved)

Recodified to N.J.A.C. 11:4–11.7 by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Section was "Effective date".

APPENDIX

LIFE INSURANCE BUYER'S GUIDE

The face page of the buyer's guide shall read as follows:

LIFE INSURANCE BUYER'S GUIDE

This guide can show you how to save money when you shop for life insurance. It helps you to:

Decide how much life insurance you should buy;

Decide what kind of life insurance policy you need; and

Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (company name)
(month and year of printing)

The buyer's guide shall contain the following language at the bottom of page 2:

The National Association of Insurance Commissioners is an association of State insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this guide in making a life insurance purchase.

THIS GUIDE DOES NOT ENDORSE ANY COMPANY OR POLICY.

The remaining text of the buyer's guide shall begin on page 3 as follows:

BUYING LIFE INSURANCE

When you buy life insurance, you want a policy which fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes which are described in this guide. A good life insurance agent or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand which kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance agent or company or books on life insurance in your public library.

CHOOSING THE AMOUNT

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

CHOOSING THE RIGHT KIND

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance:

1. Term insurance;
2. Whole life insurance;
3. Endowment insurance.

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the agent or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term Insurance: Term insurance is death protection for a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible". This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premium for the new policy will be higher than you have been paying for the term insurance.

Whole Life Insurance: Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premium for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your late years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits". This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The

amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash value may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money which you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance: An endowment insurance policy pays a sum or income to you, the policyholder, if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than for the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

FINDING A LOW COST POLICY

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "surrender cost index" and the other is the "net payment cost index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What is Cost?: "Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "nonparticipating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What are Cost Indexes?: In order to compare the cost of policies, you need to look at:

1. Premiums;
2. Cash values;
3. Dividends.

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies:

1. LIFE INSURANCE SURRENDER COST INDEX—This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare cost if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value;

2. LIFE INSURANCE NET PAYMENT COST INDEX—This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the equivalent level annual dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's equivalent level annual dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a nonparticipating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the nonparticipating policy will not change.

How Do I Use Cost Indexes?: The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a large index number. The following rules are also important:

1. Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be;

2. Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a "shopper's guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys;

3. Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost;

4. In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder;

5. These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for a while, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

IMPORTANT THINGS TO REMEMBER—A SUMMARY

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums most closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare surrender cost indexes and net payment cost indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance agent can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you can make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the agent or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

SUBCHAPTER 12. STUDENT LIFE INSURANCE

11:4–12.1 Student life insurance solicitation

(a) The purpose is to avoid any link or implication of association between a school or university and an insurance company soliciting life insurance unless specific endorsement by the school has been made.

(b) Student life insurance is life insurance offered to a person because he/she is enrolled in an institution offering a post high school education.

(c) Requirements governing the envelope in which a solicitation is mailed, delivered or offered are as follows.

1. A return address must appear in the front upper left corner of the envelope and must provide the full name and street address of the company, agent or broker soliciting the insurance, who must be identified as such. Example of a suitable return address is: Ann Doe, Insurance Agent, 00 Main Street, Chester, New Jersey 08001.

2. The return address may not use the term "office of".

3. The envelope may be addressed to "The Parents of Joan Smith" or to specifically named parents, that is, "Mr. & Mrs. Smith". The address may not include any combination of words that indicates that the correspondence is coming from the school itself rather than the insurance company or agent, nor may it imply that the school has endorsed the material and supplied the company with information about the student. Examples of unacceptable modes of address include, but are not limited to, the following:

i. "The Parents of Registered Freshman Joan Smith";

ii. "The Parents of Cornell University Student Joan Smith";

iii. "The Parents of Joan Smith, Yale Sophomore";

iv. "Tom Jones, Yale Senior".

4. If the term "Student Insurance Forms Enclosed" is used on the envelope, it must appear on one continuous line. For example, it is impermissible to divide the words so that "student insurance" appears on one line and "forms enclosed" on the next.

5. The slogan which often appears on an envelope to the left of the postal meter stamp may not focus on or mention education. Neutral slogans, such as "Buy Government Bonds" or "Support Your Local United Fund", are acceptable.

(d) Requirements governing all solicitation materials, including letters, circulars and informational flyers are as follows.

1. All material must be clearly identified as coming from an agent, broker or company, if such is the case, and these entities must be clearly identified as such.

i. Names and addresses of the soliciting agent, broker and company must appear at the top of the first page of the letter or brochure in print size no smaller than 14–point type.

ii. Logos may not be substituted for the information required above.

2. No connection between the school and the insurance company, agent or broker is to be implied unless the school has specifically endorsed the policy being sold.

3. "Office of" is prohibited from use anywhere on the materials.

4. The salutation and inside address on the solicitation material may be addressed to "The Parents of Joan Smith" or to the specifically named parents, that is, "Mr. & Mrs. Smith". The inside address may not include any combination of words that indicate that the correspondence is coming from the school itself rather than the insurance company or agent, nor may it imply that the school has endorsed the material and supplied the company with information about the student. Examples of inappropriate modes of address include, but are not limited to, the following:

i. "The Parents of Registered Freshman Joan Smith";

ii. "The Parents of Cornell University Student Joan Smith";

iii. "The Parents of Joan Smith, Yale Sophomore";

iv. "Tom Jones, Yale Senior".

(e) Records required to be maintained include the following.

1. Complete sample mailings must be on file at the home office of the insurer for a period of five years subsequent to the date of the mailings.

2. The soliciting New Jersey agent or broker must keep the same records on file as the insurer.

3. The above files shall include:

i. Description of target groups solicited;

ii. Specimen copy of mailing;

iii. Date of mailing and number of pieces mailed.

R.1977 d.254, eff. November 1, 1977.
See: 9 N.J.R. 280(a), 9 N.J.R. 372(a).

SUBCHAPTER 13. GROUP STUDENT HEALTH INSURANCE

11:4-13.1 Scope

(a) This rule prohibits certain provisions of group student health insurance policies and certificates which are unjust, unfair, inequitable, misleading, contrary to law or contrary to public policy of this State.

(b) The rule shall apply to all student health insurance policies or subscriber contracts delivered or issued for delivery after January 1, 1978.

(c) The group student health insurance continues to be subject to subchapter 13, the group coverage discontinuance and replacement rules.

11:4-13.2 Definitions

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

"Group student health insurance" is any general coverage accident and/or sickness insurance provided on a group basis to the students of a school.

"Mandatory" refers to a requirement that all students, or all students who are not already insured for the same or similar benefits under other coverages, must purchase the insurance or are billed for the coverage and must return a waiver form to obtain exemption from payment.

"Optional" means that the students may elect to purchase or to reject the insurance and are not requested to return a waiver form in order to be exempt from payment.

11:4-13.3 Prohibited provisions

(a) Rules concerning preexisting conditions are as follows.

1. Mandatory coverage: If the group student health insurance is mandatory, preexisting conditions shall not be excluded from coverage.

2. Optional coverage: When the group student health insurance is optional, the carrier may exclude conditions which existed prior to the effective date of coverage and for which the student received medical advice or treatment within a period of up to six months prior to the date the loss is incurred. Such a preexisting condition exclusion can only be applicable during the initial period of the student's coverage under the school's program.

3. Both mandatory and optional coverage:

i. Losses which commence before the effective date of the first year of coverage may be excluded;

ii. Treatment for accidental bodily injury which occurred before the effective date of the first year of coverage may be excluded unless the injury is indivisible from an accidental injury occurring during coverage.

SUBCHAPTER 14. HOME HEALTH CARE INSURANCE COVERAGE

11:4-14.1 Scope

These rules apply to individual and group health insurance policies which provide coverage for the costs of daily room and board while confined in a hospital or skilled nursing facility. They do not apply to hospital indemnity policies which provide additional income while the insured is hospitalized. These rules also do not apply to Medicare complement policies since Medicare provides home health care.

11:4–18.6 Annual review of calendar year experience data on filed individual health insurance policy forms

(a) Each insurer shall maintain records of premiums, claims, and reserves on each policy form as required for the accident and health policy experience exhibit.

(b) If the incurred/earned loss ratios for a particular policy form, based on a substantial volume of reasonably mature business, do not meet the standards set forth in section 5 of this subchapter, the insurer will be required to explain why the premiums 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 insurer, the department will inform the insurer if the benefits provided are considered unreasonable in relation to the premiums charged. If within 90 days thereafter the insurer does not reduce the premiums or increase the benefits provided in the policy such that the standards set forth in section 5 of this subchapter are met, the department may commence proceedings as provided by law for withdrawal of the filing of the form.

Amended by R.1995 d.327, effective June 19, 1995.
See: 27 N.J.R. 1513(a), 27 N.J.R. 2407(a).
Deleted (b) and relettered former (c) as (b).

11:4–18.7 Rate manual

(a) Each insurer shall maintain on file with the department an up-to-date rate manual for all individual health insurance policies, riders, and endorsements currently available for sale in New Jersey. Such manual shall include:

1. Name of the insurer on each page;

2. Table of contents or index; and

3. Identification by form number of each policy, rider, and endorsement to which the rates apply.

11:4–18.8 Separability

If any provisions of this regulation or the application thereof to any person or circumstance shall be held invalid, the invalidity shall not affect the provisions or application of this regulation which can be given effect without the invalid provision or application, and for this purpose, the provisions of this regulation are separable.

11:4–18.9 Penalties

If, after notice and hearing the commissioner finds that a person has violated this regulation a penalty, in addition to any other penalty, not exceeding $2,000 for each violation may be imposed and shall be collected and enforced pursuant to N.J.S.A. 2A:58–1 et seq.

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

11:4–18.10 Compliance

All policies of insurance previously filed with the Commissioner which are not in compliance with this subchapter as of the operative date shall be deemed to be withdrawn from filing and disapproved. No new policy of insurance shall be delivered or issued for delivery in this State until the policy has been filed with the Commissioner.

Amended by R.1988 d.473, effective October 3, 1988 (operative January 3, 1989).
See: 19 N.J.R. 1620(b), 20 N.J.R. 2457(c).
Deleted old text and substituted new.

SUBCHAPTER 19. OPTIONAL COVERAGE FOR PREGNANCY AND CHILDBIRTH BENEFITS

11:4–19.1 Purpose

The purpose of this subchapter is to prevent the exclusion of pregnancy-related surgery and sterilization procedures from certain second surgical opinion programs and to make maternity coverage available to insureds.

11:4–19.2 Scope

This subchapter shall apply to all group and individual health insurance policies as well as hospital and medical service corporation contracts delivered or issued for delivery in this State. This subchapter shall not apply to health service corporation contracts.

11:4–19.3 Second surgical opinions

Every health insurer and medical service corporation offering individual and group policies in this State, with the exception of hospital service corporations, shall include in its programs for second surgical opinions, coverage for pregnancy-related surgery and sterilization procedures.

11:4–19.4 Maternity benefits option

(a) Each insurer shall make available benefits coverage for maternity care without regard to the marital status of its policyholders, subscribers or other persons thereunder covered for expenses incurred in pregnancy and childbirth.

(b) The amount of or type of benefit coverage for maternity care expenses incurred in pregnancy and childbirth shall be provided to the same extent as benefits coverage is provided in policies and contracts for any other covered illness. Where a fixed amount of benefit coverage for surgery is prescribed by a policy or contract, benefit coverage for pregnancy-related surgical procedures shall be commensurate to that for surgery of comparable difficulty and severity.

(c) Policies which provide normal pregnancy and childbirth benefits shall cover pregnancy if conception occurs after the effective date of coverage or after a probationary

period of not more than 30 days after the effective date of the coverage.

(d) Each insurer is required to give a single notice of the option to select maternity benefits coverage to its policyholders or subscribers. While no notice of the availability of such coverage is required to be made at every renewal of a policy, the coverage itself must be made available at renewal, for the option of selection by the insured.

SUBCHAPTER 20. BLINDNESS; PARTIAL BLINDNESS OR OTHER PHYSICAL OR MENTAL IMPAIRMENTS; UNFAIR DISCRIMINATION

11:4–20.1 Purpose

The purpose of this subchapter is to eliminate unfair discrimination in the underwriting, insuring and rating of individuals who are normal insurance risks in spite of blindness, partial blindness, or other physical or mental impairments.

11:4–20.2 Unfair discriminatory acts or practices

(a) The following are hereby identified as acts or practices which constitute unfair discrimination between individuals of the same class:

1. Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness, partial blindness or other physical or mental impairments, except where the refusal, limitation or rate differential is based on sound, actuarial principles or is related to actual or reasonably anticipated experience.

Case Notes

Statute proscribing discrimination in terms and conditions of employee's health insurance policy regulated insurance within meaning of ERISA's savings clause. PAS v. Travelers Ins. Co., C.A.3 (N.J.)1993, 7 F.3d 349.

SUBCHAPTER 21. LIMITED DEATH BENEFITS FORMS

11:4–21.1 Purpose; scope

(a) The purpose of this subchapter is to establish guidelines for the filing and review of limited death benefit policy forms which will:

1. Make life insurance available to people who are otherwise uninsurable;

2. Assure that limited death policies are not sold by agents in preference to full death benefit policies and that the applicant understands that he or she may qualify for a full death benefit policy;

3. Reduce through disclosure the likelihood of misunderstanding arising where the sales presentation emphasizes the underwriting feature while minimizing or ignoring the limitation on death benefits at early durations; and

4. Set standards for the advertising of limited death benefit policy forms so as to eliminate unfair, misleading or deceptive advertising practices.

(b) This subchapter shall apply to all life insurance policy forms delivered or issued for delivery after the operative date hereof that limit death benefits during a period following the inception of the policy as an alternative to underwriting. This subchapter shall also apply to those single pay and limited pay life insurance policy forms where, at any issue age, the premium or premiums accumulated at the nonforfeiture interest rate used to determine nonforfeiture values under the policy exceed the guaranteed death benefit during the limited death benefit period defined at N.J.A.C. 11:4–21.3(g), regardless of whether the form is underwritten. The requirements in this subchapter apply to all previously filed forms as well as any forms submitted in the future. Previously filed forms which do not comply with these requirements are considered withdrawn as of August 20, 1996.

Amended by R.1996 d.82, effective February 20, 1996.
See: 27 N.J.R. 3716(a), 28 N.J.R. 1213(a).
Added single pay and limited pay life insurance policy forms.

11:4–21.2 Definitions

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

"Advertising" means any advertising materials and sales presentations in the following categories:

1. Printed and published material, audiovisual material, and descriptive literature of an insurer used in direct mail, newspapers, magazines, radio and television scripts, billboards and similar displays;

2. Descriptive literature and sales aids of all kinds issued by an insurer or agent, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters;

3. Material used for the recruitment, training and education of an insurer's sales personnel, agents, solicitors, and brokers which is designed to be used or used to induce the public to purchase, increase, modify, reinstate, or retain a policy; and

4. Prepared sales talks, presentations and material for use by sales personnel, agents, solicitors and brokers.

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

"Full death benefit policy" means any individual life insurance policy, group life insurance policy, group life insurance certificate, or fraternal benefit society certificate delivered or issued for delivery in this State which provides the full face amount as the death benefit at all times following the inception date of the policy and which provides a death benefit greater than premiums accumulated at the nonforfeiture interest rate used to determine nonforfeiture values under the policy during the limited death benefit period defined at N.J.A.C. 11:4–21.3(g).

"Limited death benefit policy" means any individual life insurance policy, group life insurance policy, group life insurance certificate, or fraternal benefit society certificate delivered or issued for delivery in this State which limits death benefits during a period following the inception date of the policy as an alternative to underwriting. Limited death benefit policies include those single pay and limited pay life insurance policy forms where, at any issue age, the premium or premiums accumulated at the nonforfeiture interest rate used to determine nonforfeiture values under the policy are equal to or in excess of the guaranteed death benefit during the limited death benefit period defined at N.J.A.C. 11:4–21.3(g), regardless of whether the form is underwritten. Limited death benefit policies also include those funeral insurance policies as defined at N.J.S.A. 17B:17–5.1a that meet the requirements set forth in N.J.A.C. 11:4–21.1(b).

Amended by R.1996 d.82, effective February 20, 1996.
See: 27 N.J.R. 3716(a), 28 N.J.R. 1213(a).
Amended "Full death benefit policy" and "Limited death benefit policy".
Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

11:4–21.3 General requirements

(a) No limited death benefit policy shall be issued in this State unless the insurer has, at the time of application, obtained from the applicant a signed and dated statement attesting that the applicant understands that he or she may qualify for a full death benefit policy which provides full benefits from inception. A copy of this statement must be submitted to the Department for review prior to its use.

(b) All advertising of a limited death benefit policy and any revisions to the advertising must be submitted to the Department prior to use. The material submitted must include a narrative statement of the method by which the policy will be sold.

(c) All advertising for a limited death benefit policy shall prominently explain the nature of the limited death benefit policy and state the duration of the limited death benefit period.

(d) Any advertising of a limited death benefit policy which makes reference to a specific premium rate must provide:

1. For other than radio and television, a listing of the rates and benefits for all available ages (male and female); and

2. For radio and television, instructions in the procedure to be followed by the applicant to learn what benefits and rates are available.

(e) When sold by agents, the commission may not be greater on the sale of limited death benefit policies than on the sale of full death benefit policies.

(f) The limited death benefit shall not be less than the amount of premiums paid with interest at the rate used to determine nonforfeiture values under the policy.

(g) The period during which a limited death benefit applies shall not exceed 25 percent of life expectancy at the issue age, as determined by the mortality table used for nonforfeiture values under the policy, or two years, whichever is shorter.

(h) The policy shall include a provision allowing for the return of the policy for a full refund of premiums within 30 days after delivery.

Amended by R.1996 d.82, effective February 20, 1996.
See: 27 N.J.R. 3716(a), 28 N.J.R. 1213(a).
Eliminated amount and issue age limitations.

11:4–21.4 Severability

If any provision of this subchapter, or its application to any person or circumstances, is held invalid, the remainder of this subchapter and its application to other persons or circumstances shall not be affected.

SUBCHAPTER 22. INDIVIDUAL LIFE INSURANCE: USE OF GENDER BLENDED MORTALITY TABLES

11:4–22.1 Purpose

The purpose of this subchapter is to permit individual life insurance policies to provide the same cash surrender values and paid-up nonforfeiture benefits to both men and women. No change in minimum valuation standards is intended by these rules.

11:4–22.2 Definitions

The following words and terms when used in this subchapter shall have the following meanings:

"1980 CSO Table, with or without Ten Year Select Mortality Factors" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 National Association of Insurance Commissioners (NAIC) Amendments to the Model Standard Valuation Law and Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioner's 1980 Standard Ordinary Mortality Table, with or without Ten–Year Select Mortality Factors.

"1980 CSO Table (M), with or without Ten–Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for male lives from the 1980 CSO Table, with or without Ten–Year Select Mortality Factors.

"1980 CSO Table (F), with or without Ten–Year Select Mortality Factors" means that mortality table consisting of the rates of mortality for female lives from the 1980 CSO Table, with or without Ten–Year Select Mortality Factors.

"1980 CET Table" means that mortality table consisting of separate rates of mortality for male and female lives, developed by the Society of Actuaries Committee to Recommend New Mortality Tables for Valuation of Standard Individual Ordinary Life Insurance, incorporated in the 1980 NAIC Amendments to the Model Standard Valuation Law and Model Standard Nonforfeiture Law for Life Insurance, and referred to in those models as the Commissioner's 1980 Extended Term Insurance Table.

"1980 CET Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 1980 CET Table.

"1980 CET Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 1980 CET Table.

"1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables" mean the mortality tables with separate rates of mortality for smokers and nonsmokers derived from the 1980 CSO and 1980 CET Mortality Tables by the Society of Actuaries Task Force on Smoker/Nonsmoker Mortality and adopted by the NAIC in December 1983.

"Non–*Norris* market" means all employer-based plans not included within the definition of "*Norris* market" set forth in this subchapter.

"*Norris* market" means all employer-based plans subject to the holding of the 1983 *Arizona Governing Committee v. Norris* United States Supreme Court decision (463 *U.S.* 1073).

Amended by R.1987 d.394, effective October 5, 1987.
See: 19 N.J.R. 1399(a), 19 N.J.R. 1814(a).

Added definition "1980 CSO and 1980 CET Smoker and Nonsmoker Mortality Tables".
Amended by R.1996 d.148, effective March 18, 1996.
See: 27 N.J.R. 3717(a), 28 N.J.R. 1545(a).
Added "Norris market" and "Non-Norris market".

11:4–22.3 Construction of gender blended tables for use in the determination of minimum nonforfeiture benefits and minimum reserves

(a) For any policy of insurance on the life of either a male or female insured delivered or issued for delivery in this State after September 11, 1981, a life insurer which has elected or which elects an operative date under N.J.S.A. 17B:25–19h(xi) may file with the Department of Insurance for use as part of the policy form, the approved gender blended mortality tables as described in (b) below and attached as the Appendix to this subchapter, or a description thereof, to determine minimum cash surrender values and minimum amounts and minimum periods of paid-up nonforfeiture benefits.

1. An approved mortality table which is a blend of the 1980 CSO Table (M) and the 1980 CSO Table (F) with or without Ten–Year Select Mortality Factors may at the option of the company be substituted for the 1980 CSO Table, with or without our Ten–Year Select Mortality Factors; and

2. A mortality table which is of the same blend as used in (a)1 above but applied to form a blend of the 1980 CET Table (M) and the 1980 CET Table (F) may at the option of the company be substituted for the 1980 CET Table.

(b) The following describes the gender blended tables approved for use pursuant to N.J.S.A. 17B:25–19h(viii). These tables are contained in the Appendix to this subchapter and are part of this subchapter:

1. 100 percent Male 0 percent Female for tables to be designated as the "1980 CSO–A" and "1980 CET–A" tables:

2. 80 percent Male 20 percent Female for tables to be designated as the "1980 CSO–B" and "1980 CET–B" tables;

3. 60 percent Male 40 percent Female for tables to be designated as the "1980 CSO–C" and "1980 CET–C" tables;

4. 50 percent Male 50 percent Female for tables to be designated as the "1980 CSO–D" and "1980 CET–D" tables;

5. 40 percent Male 60 percent Female for tables to be designated as the "1980 CSO–E" and "1980 CET–E" tables;

6. 20 percent Male 80 percent Female for tables to be designated as the "1980 CSO–F" and "1980 CET–F" tables;

for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]*
- other approved items and services

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].*

*** Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

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

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.
This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]*
- other approved items and services

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].*

*** Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

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

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

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.
This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]*
- other approved items and services

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].*

*** Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

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

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.
This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]*
- other approved items and services

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].*

* **Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

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

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

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.
This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]*
- other approved items and services

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or your state [health] insurance [assistance] program [SHIP].*

* Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

Amended by R.1991 d.121, effective March 4, 1992.
See: 22 N.J.R. 771(a), 23 N.J.R. 690(e).
Amended Appendix text throughout in order to update and clarify changes in Medicare and secondary insurance coverage. Reorganized appendix into Exhibits A through C, with Exhibit C adding new text. Deleted information insert, "Information Concerning Changes to the Medicare Program Effective January 1, 1989," because it is obsolete.
Amended by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).
APPENDIX substantially revised.
Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
Exhibits A and B, repealed.
Amended by R.1996 d.295, effective July 1, 1996.
See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).
Amended by R.1999 d.161, effective May 17, 1999.
See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).
Repeal and New Rule, R.2005 d.291, effective September 6, 2005.
See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Rewrote the section.

11:4–26.2 Definitions

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

"Annuity 2000 Mortality Table" means that mortality table developed by the Society of Actuaries Committee on Life Insurance Research and shown on page 240 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

"NAIC" means the National Association of Insurance Commissioners.

"1983 Table 'a' " means that mortality table developed by the Society of Actuaries Committee to Recommend a New Mortality Basis for Individual Annuity Valuation and adopted as a recognized mortality table for annuities in June 1982 by the National Association of Insurance Commissioners (see *1982 Proceedings of the NAIC II*, page 454).

"1983 GAM Table" means that mortality table developed by the Society of Actuaries Committee on Annuities and adopted as a recognized mortality table for annuities in December 1983 by the National Association of Insurance Commissioners (see *1984 Proceedings of the NAIC I*, pages 414 to 415).

"1994 GAR Table" means that mortality table developed by the Society of Actuaries Group Annuity Valuation Table Task Force and shown on pages 866–867 of Volume XLVII of the *Transactions of the Society of Actuaries* (1995).

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Rewrote the section.

11:4–26.3 Individual annuity or pure endowment contracts

(a) Except as provided in (b) and (c) below, the 1983 Table "a" is recognized and approved as an individual annuity mortality table for valuation and, at the option of the company, may be used for purposes of determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after September 11, 1981.

(b) Except as provided in (c) below, either the 1983 Table "a" or the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 1987.

(c) Except as provided in (d) below, the Annuity 2000 Mortality Table shall be used for determining the minimum standard of valuation for any individual annuity or pure endowment contract issued on or after January 1, 2001.

(d) The 1983 Table "a" without projection is to be used for determining the minimum standard of valuation for an individual annuity or pure endowment contract issued on or after January 1, 2001, solely when the contract is based on life contingencies and is issued to fund periodic benefits arising from:

1. Settlements of various forms of claims pertaining to court settlements or out of court settlements from tort actions;

2. Settlements involving similar actions such as worker's compensation claims; or

3. Settlements of long term disability claims where a temporary or life annuity has been used in lieu of continuing disability payments.

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Rewrote the section.

11:4–26.4 Group annuity or pure endowment contracts

(a) Except as provided in (b) and (c) below, the 1983 GAM Table, the 1983 Table "a" and the 1994 GAR Table are recognized and approved as group annuity mortality tables for valuation and, at the option of the company, any one of these tables may be used for purposes of valuation for any annuity or pure endowment purchased on or after September 11, 1981 under a group annuity or pure endowment contract.

(b) Except as provided in (c) below, either the 1983 GAM Table or the 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 1987 under a group annuity or pure endowment contract.

(c) The 1994 GAR Table shall be used for determining the minimum standard of valuation for any annuity or pure endowment purchased on or after January 1, 2001 under a group annuity or pure endowment contract.

Amended by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Rewrote the section.

11:4–26.5 Application of the 1994 GAR Table

(a) In using the 1994 GAR Table, the mortality rate for a person age x in year (1994+n) is calculated as follows:

$$q_x^{1994+n} = q_x^{1994} (1\ AA_x)^n$$

where the q_x^{1994} and AA_xs are as specified in the 1994 GAR Table.

New Rule, R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).
Former N.J.A.C. 11:4–26.5, Separability, recodified to N.J.A.C. 11:4–26.6.

11:4-26.6 Separability

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

Recodified from N.J.A.C. 11:4-26.5 by R.2001 d.7, effective January 2, 2001.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

SUBCHAPTER 27. THE 2001 COMMISSIONER'S STANDARD ORDINARY (CSO) MORTALITY TABLE FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES AND NONFORFEITURE BENEFITS

Authority

N.J.S.A. 17:1-8.1, 17:1C-6e, 17B:25-19, and 17B:30-1 et seq.

Source and Effective Date

R.2004 d.415, effective November 1, 2004.
See: 36 N.J.R. 3477(a), 36 N.J.R. 4937(a).

11:4-27.1 Purpose and scope

This subchapter sets forth the requirements for the use of the 2001 Commissioner's Standard Ordinary (CSO) Mortality Table in accordance with N.J.S.A. 17B:19-8a(i), N.J.S.A. 17B:25-19h(viii), N.J.A.C. 11:4-32.3(a) and N.J.A.C. 11:4-32.3(b).

11:4-27.2 Definitions

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

"2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is reproduced in subchapter Appendices 1 through 7, incorporated herein by reference, and is included in the *Proceedings of the NAIC* (2nd Quarter 2002). See www.naic.org and www.actuary.org/life/cso_0702.htm. Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

"2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

"2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

"Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

"Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

11:4-27.3 2001 CSO Mortality Table effective dates

(a) At the election of the insurer for any one or more specified plans of insurance and subject to the conditions stated in this subchapter, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after January 1, 2005 and before January 1, 2009 to which N.J.S.A. 17B:19-8a(i), N.J.S.A. 17B:25-19h(viii) and N.J.A.C. 11:4-32.3(a) and (b) are applicable. If the company elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes.

(b) Subject to the conditions stated in this subchapter, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on or after January 1, 2009, to which N.J.S.A. 17B:19-8a(i), N.J.S.A. 17B:25-19h(viii) and N.J.A.C. 11:4-32.3(a) and (b) are applicable.

11:4-27.4 Conditions

(a) For each plan of insurance with separate rates for smokers and nonsmokers, an insurer may use:

1. Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

2. Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by N.J.S.A. 17B:19-8(e) and may use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

3. Smoker and nonsmoker mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(b) For plans of insurance without separate rates for smokers and nonsmokers, the composite mortality tables shall be used.

SUBCHAPTER 35. VIATICAL SETTLEMENTS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e and 17B:30A-1 et seq.

Source and Effective Date

R.2001 d.226, effective July 2, 2001.
See: 33 N.J.R. 162(a), 33 N.J.R. 2300(a).

11:4-35.1 Purpose and scope

(a) The purpose of this subchapter is to implement N.J.S.A. 17B:30A-1 et seq. governing viatical settlements.

(b) This subchapter applies to persons who enter into agreements with New Jersey residents to purchase their life insurance policies for less than the current death benefit.

11:4-35.2 Definitions

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

"Act" means an Act concerning life insurance viatical settlements approved September 17, 1999, N.J.S.A. 17B:30A-1 et seq.

"Commissioner," unless otherwise stated, means the Commissioner of the Department of Banking and Insurance.

"Department" means the Department of Banking and Insurance.

"Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any person who may be a party to a viatical settlement contract and who has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract but whose sole activity related to the transaction is providing funds to effect the viatical settlement and who has an agreement in writing with a licensed viatical settlement provider to act as a participant in a financing transaction.

"Financing transaction" means a transaction in which a licensed viatical settlement provider or a financing entity obtains financing for viatical settlement contracts, viaticated policies or interests therein including, without limitation, any secured or unsecured financing, any securitization transaction or any securities offering either registered or exempt form registration under Federal and State securities law, or any direct purchase of interests in a certificate, if the financing transaction complies with Federal and State securities law.

"Insured" means the person covered under the policy being considered for viatication.

"Mean life expectancy" means the mean number of months the individual insured under the life insurance policy to be viaticated can be expected to live as determined by the viatical settlement provider, considering medical records and appropriate experiential data.

"Net death benefit" means the amount of the life insurance policy or certificate to be viaticated less any outstanding debts or liens.

"Patient identifying information" means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

"Person" means any individual, corporation, organization, firm, association, partnership or other legal entity.

"Resident (of New Jersey)" means a person who either resides in New Jersey or maintains an office in New Jersey where business is transacted.

"Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in 24 months or less.

"Viatical settlement broker" means a person who on behalf of a viator and for a fee, commission or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers. Irrespective of the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, accountant or financial planner retained to represent the viator whose compensation is paid directly by or at the direction of the viator.

"Viatical settlement contract" means a written agreement entered into between a viatical settlement provider and a viator. The agreement shall establish the terms under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise or bequest of the death benefit or ownership of all or a portion of the insurance policy or certificate of insurance. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurer pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

"Viatical settlement provider" means a person, other than a viator, who enters into a viatical settlement contract. Viatical settlement provider also means a person who obtains financing from a financing entity for the purchase, acquisition, transfer or other assignment of one or more viatical settlement contracts, viaticated policies or interests therein, or otherwise sells, assigns, transfers, pledges, hypothecates or otherwise disposes of one or more viatical

settlement contracts, viaticated policies or interests therein. Viatical settlement provider does not include:

1. A bank, savings bank, savings and loan association, credit union or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

2. The issuer of a life insurance policy providing accelerated benefits pursuant to N.J.A.C. 11:4-30 and pursuant to the policy; or

3. A natural person who enters into no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit.

"Viatical settlement representative" means a person who is an authorized agent of a licensed viatical settlement provider or viatical settlement broker, as applicable, who acts or aids in any manner in the solicitation of a viatical settlement. Viatical settlement representative shall not include:

GROUP HEALTH (SERVICE CORP.)

CODE	COVERAGE TYPE
U0	Group Medical Expense (Service Corp.)
U1	Group Medicare Supplement (Service Corp.)
U4	Group Long Term Care (Service Corp.)
U5	Group Dental (Service Corp.)
U6	Group Accident Only (Service Corp.)
U7	Group Blanket Insurance (Service Corp.)
U8	Group Student Coverage (Service Corp.)
U9	Group Stop Loss Coverage (Excess Coverage) (Service Corp.)
UZ	Other (Group Health Service Corp.)

Notes: Use the form number on the face page of a policy or certificate when type of form is PP or CC (A complete policy or certificate). (Complete Applications, Endorsements, and Riders with multiple pages can be coded the same way.)
When the submission contains multiple insert pages (not a complete policy or certificate) only the first form number should be coded followed by the suffix et al. Use the Form Type CI or PI.

INDIVIDUAL CREDIT

CODE	COVERAGE TYPE
90	Credit Life—Single Premium
91	Credit Health—Single Premium
92	Credit Life—MOB
93	Credit Health—MOB
94	Credit L & H—Truncated Coverage
95	Credit L & H—Leases
96	Mortgage Life
97	Mortgage Health
98	Other Credit (Riders & Endorsements)
99	Critical Period Coverage (Individual Credit)
9Y	Combination of Coverage (Individual Credit)

GROUP CREDIT

CODE	COVERAGE TYPE
9A	Credit Life—Single Premium (Group)
9B	Credit Health—Single Premium (Group)
9C	Credit Life—MOB (Group)
9D	Credit Health—MOB (Group)
9E	Credit L & H—Truncated Coverage (Group)
9F	Credit L & H—Leases (Group)
9G	Mortgage Life (Group)
9H	Mortgage Health (Group)
9I	Other Credit (Riders & Endorsements) (Group)
9J	Critical Period Coverage (Group Credit)
9K	Combination of Coverage (Group Credit)

MORTGAGE GUARANTEE

CODE	COVERAGE TYPE
MG	Mortgage Guarantee

Notes: Use codes other than 98 or 9I to classify policies, certificates, and notices which apply to a particular sort of insurance.
Use codes 98 and 9I for forms that apply to all sorts of coverage (i.e., certificates of assumption).
Combination of Coverage code is used when a rider, endorsement or application are intended for use with more than one Coverage Type.

SUBCHAPTER 40A. "40 STATES" FILE AND USE STANDARDS AND PROCEDURES

Authority

N.J.S.A. 17:1–8.1, 17:1–15e and P.L. 2001, c.237 (codified as N.J.S.A. 17B:25–18.4).

Source and Effective Date

R.2003 d.140, effective April 7, 2003.
See: 34 N.J.R. 3916(a), 35 N.J.R. 1555(a).

11:4–40A.1 Purpose and scope

(a) The purpose of this subchapter is to implement P.L. 2001, c.237 (N.J.S.A. 17B:25–18.4), which establishes a special procedure whereby insurers may forego prior approval of certain life insurance, annuity and variable contract forms.

(b) This subchapter shall apply to all individual life insurance, individual annuity, group annuity, group life, variable life and variable annuity contract forms to be issued by an insurer authorized to do business in this State. This subchapter shall not apply to any health insurance policy, or contract forms or benefits, including specified disease or critical illness policies, contracts or benefits.

11:4–40A.2 Definitions

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

"Annuity" means all contracts meeting the definition set forth at N.J.S.A. 17B:17–5.

"Available for sale or use" means that the insurer has complied with the state's laws, regulations, and procedures to allow the insurer to sell or use the form in that state.

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

"Department" means the Department of Banking and Insurance.

"Form," "contract form" and "policy form" mean all annuity contract forms; all life insurance policy and contract forms; all variable contract forms; and all group insurance certificates as defined within this subchapter, including endorsements, riders and application forms.

"Health insurance" means all policies, contracts and benefits meeting the definition set forth at N.J.S.A. 17B:17–4,

including specified disease and critical illness policies, contracts and benefits as defined at N.J.A.C. 11:4–53.

"Improper certification" means providing any misrepresentation or false statement material to a certification form.

"Life insurance" means all policies and contracts meeting the definition set forth at N.J.S.A. 17B:17–3.

"Responsible officer of the insurer" means a corporate officer of the level of vice president or higher, or of equivalent title within the insurer's structure, who is either the actuary of the insurer with responsibility for the type of form filed, or the individual with responsibility for managing the form filing process for the insurer with regard to the type of form filed.

"Unique product features or design" means that the contract language that expresses the methodology used to calculate values, benefits and rates is materially the same. Nonmaterial differences include unique requirements mandated by a state's law (for example, mandated use of a unisex mortality table); synonyms used (for example, "period" instead of "term," "face amount" instead of "insurance amount"); and quantitative differences of no more than 10 percent (for example, one policy contains a $50.00 charge, while another contains a $55.00 charge). Standard contract provisions are not considered part of the unique product feature or design.

"Variable contracts" means all contracts meeting the definition set forth at N.J.S.A. 17B:28–1 et seq.

11:4–40A.3 Eligibility

(a) Forms submitted to the Commissioner on the basis that they have been made available for sale or use in 40 states, subject to state variations that do not alter the unique features or design of the product, shall be eligible for sale or use pursuant to the requirements of this subchapter. Notwithstanding eligibility, any such form shall comply with New Jersey law regarding standard contract provisions as identified below.

1. Individual Life:

i. Free Look as set forth in N.J.S.A. 17B:25–2.1;

ii. Grace Period as set forth in N.J.S.A. 17B:25–3;

iii. Incontestability as set forth in N.J.S.A. 17B:25–4, 16 and 17;

iv. Entire Contract as set forth in N.J.S.A. 17B:25–5;

v. Misstatement of Age as set forth in N.J.S.A. 17B:25–6;

vi. Dividends as set forth in N.J.S.A. 17B:25–7;

vii. Policy Loan as set forth in N.J.S.A. 17B:25–8;

viii. Reinstatement as set forth in N.J.S.A. 17B:25–9;

ix. Payment of Premium as set forth in N.J.S.A. 17B:25–10;

x. Automatic Premium Loan Notice as set forth in N.J.S.A. 17B:25–10.1;

xi. Payment of Claims as set forth in N.J.S.A. 17B:25–11;

xii. Beneficiary as set forth in N.J.S.A. 17B:25–12;

xiii. Nonforfeiture Benefits as set forth in N.J.S.A. 17B:25–19(a) and (*l*);

xiv. Title as set forth in N.J.S.A. 17B:25–14; and

xv. Period in Which to Commence Cause of Action as set forth in N.J.S.A. 17B:25–15;

2. Group Life:

i. Requirements for Eligible Groups as set forth in N.J.S.A. 17B:27–1;

ii. Dependents as set forth in N.J.S.A. 17B:27–9;

iii. Grace Period as set forth in N.J.S.A. 17B:27–11;

iv. Incontestability as set forth in N.J.S.A. 17B:27–12;

v. Application, Representations not Warranties, Entire Contract as set forth in N.J.S.A. 17B:27–13;

vi. Evidence of Insurability as set forth in N.J.S.A. 17B:27–14;

vii. Age Adjustments as set forth in N.J.S.A. 17B:27–15;

viii. Participating Policies as set forth in N.J.S.A. 17B:27–16;

ix. Beneficiary and Facility of Payment as set forth in N.J.S.A. 17B:27–17;

x. Certificates as set forth in N.J.S.A. 17B:27–18;

xi. Conversion as set forth in N.J.S.A. 17B:27–19 and 20;

xii. Death within Conversion Period as set forth in N.J.S.A. 17B:27–21;

xiii. Certificate to Debtors as set forth in N.J.S.A. 17B:27–22; and

xiv. Conversion of Debtors as set forth in N.J.S.A. 17B:27–23;

3. Individual Annuity:

i. Standard Nonforfeiture Law as set forth in N.J.S.A. 17B:25–20(f), (*l*), (*o*) and (p);

ii. Misstatement of Age or Sex as set forth in N.J.A.C. 11:4–43.3(c)4; and

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 certifications shall be mailed to the following address:

New Jersey Department of Banking and Insurance
Life and Health Division
Life Bureau Actuary
PO Box 470
Trenton, New Jersey 08625–0470

One copy of the certifications shall be mailed to the following address:

New Jersey Department of Banking and Insurance
Division of Enforcement and Consumer Protection
PO 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 of the fact within 10 days and disclose the reason for the change.

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

Authority

N.J.S.A. 17:1–8.1, 17:1–15e, 17B:26–1h, 17B:26–45, 17B:30–1 et seq. and 17B:27–49.

Source and Effective Date

R.2001 d.363, effective October 1, 2001.
See: 33 N.J.R. 361(a), 33 N.J.R. 3454(c).

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."

EXHIBIT B

SPECIFIED DISEASE/CRITICAL ILLNESS POLICY

CALENDAR YEAR EXPERIENCE DATA

CARRIER NAME _____ NAME OF PERSON COMPLETING FORM _____

ADDRESS _____

TITLE _____ PHONE _____

POLICY FORM NO.* _____ DATE _____

DATE POLICY FILED BY NJ _____ ORIGINAL ANTICIPATED LOSS RATIO _____

YEAR	NATIONWIDE DATA				NEW JERSEY DATA			
	#of Policies in Force	Paid Premium	Paid Claims	Loss Ratio	#of Policies in Force	Paid Premium	Paid Claims	Loss Ratio
2001								
2002								
2003								
2004								
2005								
2006								
2007								
2008								
2009								
2010								

* Complete one report for each policy form for which policies issued in New Jersey remain inforce.

Return completed reports to: New Jersey Department of Banking and Insurance
Health Insurance Bureau
PO Box 470
Trenton, NJ 08625

Amended by R.2002 d.7, effective January 7, 2002.
See: 33 N.J.R. 3425(a), 34 N.J.R. 283(a).
In final paragraph of Exhibit A, amended the anticipated loss ratio for individual policies from 65 to 60 percent.

SUBCHAPTER 54. BENEFIT STANDARDS FOR INFERTILITY COVERAGE

Authority

N.J.S.A. 17:1-8.1 and 15e; P.L. 2001, c.236.

Source and Effective Date

R.2003 d.160, effective April 21, 2003.
See: 34 N.J.R. 2521(a), 35 N.J.R. 1692(b).

11:4-54.1 Purpose and scope

(a) The purpose of this subchapter is to implement P.L. 2001, c.236 by establishing uniform definitions of terms associated with infertility coverage and benefits that must be provided for infertility in this State.

(b) This subchapter shall apply to the following:

1. All policies, contracts, riders and endorsements delivered, issued, executed or renewed in this State by health service corporations, hospital service corporations, medical service corporations and health insurance companies for groups other than small employers as defined at N.J.S.A. 17B:27A-17 that provide hospital or medical benefits, including pregnancy-related benefits;

2. All contracts and evidence of coverage forms issued by health maintenance organizations for groups other than small employers as defined at N.J.S.A. 17B:27A-17 that include pregnancy-related coverage; and

3. All certificates and evidence of coverage forms delivered, issued, executed or renewed in this State where the related group policy or contract is delivered, issued, executed or renewed in this State for groups other than small employers as defined at N.J.S.A. 17B:27A-17 that provide hospital or medical benefits, including pregnancy-related benefits.

(c) This subchapter shall not apply to any policy or contract which, pursuant to a contract between a carrier and the New Jersey Department of Human Services, provides benefits to persons who are eligible for medical assistance under P.L. 1968, c.413 (N.J.S.A. 30:4D-1 et seq.); the

Children's Health Care Coverage program under P.L. 1997, c.272 (N.J.S.A. 30:4I-1 et seq.); the FamilyCare Health Coverage Program under P.L. 2000, c.71 (N.J.S.A. 30:4J-1 et seq.); or any other program administered by the Division of Medical Assistance and Health Services in the New Jersey Department of Human Services.

11:4-54.2 Definitions

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

"Artificial insemination" means the introduction of sperm into a woman's vagina or uterus by noncoital methods for the purpose of conception, and includes intrauterine insemination.

"Assisted hatching" means a micromanipulation technique in which a hole is artificially created in the outer shell of an embryo to assist with the potential implantation of that embryo.

"Carrier" means a health service corporation, hospital service corporation, medical service corporation, insurance company and a health maintenance organization.

"Completed egg retrieval" means all office visits, procedures and laboratory and radiological tests performed in preparation for oocyte retrieval; the attempted or successful retrieval of the oocyte(s); and, if the retrieval is successful, culture and fertilization of the oocyte(s).

"Cryopreservation" means the freezing of embryos in liquid nitrogen until such time as required for a frozen embryo transfer. Cryopreservation also refers to the freezing of female gametes (ova) and male gametes (sperm).

"Egg retrieval" or "oocyte retrieval" means a procedure by which eggs are collected from a woman's ovarian follicles.

"Egg transfer" or "oocyte transfer" means the transfer of retrieved eggs into a woman's fallopian tubes through laparoscopy as part of gamete intrafallopian transfer (GIFT).

"Embryo" means a fertilized egg that has begun cell division and has completed the pre-embryonic stage.

"Embryo transfer" means the placement of an embryo into the uterus through the cervix or, in the case of zygote intrafallopian tube transfer (ZIFT), the placement of an embryo in the fallopian tube. Embryo transfer includes the transfer of cryopreserved embryos and donor embryos.

"Fertilization" means the penetration of the egg by the sperm.

"Gamete" means a reproductive cell. In a male, gametes are sperm; in a female, gametes are eggs or ova.

"Gamete intrafallopian tube transfer" or "GIFT" means the direct transfer of a sperm/egg mixture into the fallopian tube by laparoscopy. Fertilization takes place inside the fallopian tube.

"Gestational carrier" means a woman who has become pregnant with an embryo or embryos that are not part of her genetic or biologic entity, and who intends to give the child to the biological parents after birth.

"Infertility" means a disease or condition that results in the abnormal function of the reproductive system such that:

1. A male is unable to impregnate a female;

2. A female under 35 years of age is unable to conceive after two years of unprotected sexual intercourse;

3. A female 35 years of age and over is unable to conceive after one year of unprotected sexual intercourse;

4. The male or female is medically sterile; or

5. The female is unable to carry a pregnancy to live birth.

Infertility shall not mean a person who has been voluntarily sterilized regardless of whether the person has attempted to reverse the sterilization.

"Infertility coverage" means coverage required by P.L. 2001, c.236 for the diagnosis and treatment of infertility.

"Intracytoplasmic sperm injection" or "ICSI" means a micromanipulation procedure whereby a single sperm is injected into the center of an egg.

"Intrauterine insemination" means a medical procedure whereby sperm is placed into a woman's uterus to facilitate fertilization.

"In vitro fertilization" or "IVF" means an ART procedure whereby eggs are removed from a woman's ovaries and fertilized outside her body. The resulting embryo is then transferred into a woman's uterus.

"Microsurgical sperm aspiration" means the techniques used to obtain sperm for use with intracytoplasmic sperm injection (ICSI) in cases of obstructive azoospermia. It can involve the extraction of sperm and fluid from epididymal tubules inside the epididymis ("MESA") or the provision of testicular tissue from which viable sperm may be extracted ("TESE").

"Oocyte" means the female egg or ovum.

"Ovulation induction" means the use of drugs (oral or injected) to stimulate the ovaries to develop follicles and eggs.

"Pregnancy-related benefits" means benefits for normal pregnancy and childbirth.

"Religious employer" means an employer that is a church, convention or association of churches, or any group or entity that is operated, supervised or controlled by or in connection with a church, convention or association of churches, as defined in 26 U.S.C. § 3121(w)(3)(A) (Federal Insurance Contributions Act) and that qualifies as a tax-exempt organization under 26 U.S.C. § 501(c)(3) (Internal Revenue Code, Exempt Organizations).

"Sexual intercourse" means sexual union between a male and a female.

"Surrogate" means a woman who carries an embryo that was formed from her own egg inseminated by the sperm of a designated sperm donor.

"Zygote" means a fertilized egg before cell division begins.

"Zygote intrafallopian tube transfer" or "ZIFT" means a procedure whereby an egg is fertilized in vitro, and the zygote is transferred to the fallopian tube at the pronuclear stage before cell division takes place.

11:4–54.3 Infertility coverage provided to the same extent as other pregnancy-related procedures

(a) A carrier shall not impose a separate copayment, coinsurance, deductible, dollar maximum, visit maximum or procedure maximum on any infertility treatment other than limiting infertility coverage to four completed egg retrievals per lifetime of the covered person.

(b) A carrier shall not impose a separate preauthorization notice or other utilization management requirement on infertility treatment. (For example, if a carrier requires all hospitalizations or all surgeries to be preauthorized, and a particular infertility treatment is to be performed during a hospitalization or is a surgical procedure, the carrier may require preauthorization of the treatment. But a carrier shall not require that all infertility treatments be preauthorized.)

(c) A carrier may limit benefits required to be provided pursuant to this subchapter to services performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. Carriers shall not impose any additional standards in the group policy or contract and in the certificate or evidence of coverage applicable to fertility services on facilities or other providers.

11:4–54.4 Required benefits

(a) Infertility coverage shall include, but is not limited to, payment of benefits for the following services and procedures recognized by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists:

1. Artificial insemination with no limit as to the number of cycles;

2. Assisted hatching;

3. Diagnosis and diagnostic tests;

4. Fresh and frozen embryo transfer;

5. Four completed egg retrievals per lifetime of the covered person;

i. Where a live donor is used in the egg retrieval, the medical costs of the donor shall be covered until the donor is released from treatment by the reproductive endocrinologist;

ii. Egg retrievals where the cost was not covered by any carrier shall not count in determining whether the four completed egg retrieval limit has been met;

6. Gamete intrafallopian transfer and zygote intrafallopian transfer;

7. Intracytoplasmic sperm injections;

8. In vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate;

9. Medications, including injectible infertility medications, even if the contract or policy does not provide prescription drug benefits. Where a contract or policy provides both prescription drug and medical and hospital benefits, infertility drugs shall be covered under the prescription drug coverage;

10. Ovulation induction; and

11. Surgery, including microsurgical sperm aspiration.

11:4–54.5 Permissible benefit exclusions

(a) Following are the only permissible exclusions from the infertility benefit requirements of this subchapter:

1. Reversal of voluntary sterilization.

i. Coverage for infertility services provided to partners of persons who have successfully reversed sterilization may not be excluded provided that the partner is infertile as defined by P.L. 2001, c.236 and this subchapter;

2. Payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier's policy or contract;

3. Costs associated with cryopreservation and storage of sperm, eggs and embryos;

4. Nonmedical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist;

5. Infertility treatments that are experimental or investigational in nature;

6. Ovulation kits and sperm testing kits and supplies;

7. In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for infertility, who have exceeded the limit of four covered completed egg retrievals, or who are 46 years of age or older; and

8. Group policies, contracts, riders and endorsements that provide hospital or medical benefits, other than policies or contracts that provide prescription drug benefits only, may provide that infertility medication benefits are excluded if infertility medication benefits are provided under another group health insurance policy or contract issued to the same policyholder or contractholder.

11:4-54.6 Religious employer exclusions

(a) A carrier shall exclude coverage for in vitro fertilization, embryo transfer, artificial insemination, zygote intrafallopian transfer, gamete intrafallopian transfer, and intracytoplasmic sperm injection at the request of a religious employer only if the required coverage is contrary to the religious employer's bona fide religious tenets.

(b) A carrier that issues a policy or contract containing a religious employer exclusion shall provide written notice of such exclusion to each prospective insured or covered person. Such notice shall appear in not less than 10-point type in the certificate or evidence of coverage, the covered person's application or enrollment form, and all sales and marketing materials.

11:4-54.7 Effect on previously filed forms

Forms previously filed or approved by the Commissioner pursuant to N.J.S.A. 17B:27-49 and 26:2J-43 that contain provisions not in compliance with this subchapter shall be deemed withdrawn and shall not be delivered, issued, executed or renewed.

SUBCHAPTER 55. PHARMACY CARDS

Authority

N.J.S.A. 17:1-8.1 and 17B:30-39.

Source and Effective Date

R.2004 d.433, effective November 15, 2004.
See: 36 N.J.R. 1873(a), 36 N.J.R. 5131(a).

11:4-55.1 Definitions

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

"ANSI identification number" means the American National Standards Institute (ANSI) International ID Number assigned to the administrator or pharmacy benefits manager of the health benefits plan. The label for this number is "RxBIN."

"Card" means a card or other technology that functions like a card.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State.

"Comprehensive pharmacy benefits" means benefits covering prescription drugs on an outpatient basis, irrespective of whether the benefits are provided by a network of participating pharmacies, and irrespective of whether the benefits are in the form of the prescription drugs themselves or are in the form of reimbursement for the cost of the prescription drugs. "Comprehensive pharmacy benefits" shall not mean benefits limited to prescription drugs provided in connection with mandated benefits for specific diseases or conditions.

"Group number" means the group number for the insured. The label for this number is "RxGRP."

"Health benefits plan" means:

1. A health benefits plan that is delivered or issued for delivery in this State by or through a carrier;

2. A plan provided by a multiple employer welfare arrangement; or

3. A plan provided by another benefit arrangement, to the extent permitted by the "Employee Retirement Income Security Act of 1974," Pub. L. 93-406 (29 U.S.C. §§ 1001 et seq.), or by any waiver of or other exception to that act provided under Federal law or regulation. "Health benefits plan" shall include prescription-only coverage.

"Health benefits plan" shall not mean:

1. Accident-only insurance;

2. Credit accident and health insurance;

3. Medicare supplement insurance;

4. Medicaid fee-for-service;

5. Disability income insurance;

6. Long-term care insurance;

7. Specified disease insurance;

8. Dental or vision care plan;

9. Hospital indemnity insurance;

10. Coverage issued as a supplement to liability insurance;

11. Medical payments under automobile or homeowners insurance; or

12. Insurance under which benefits are payable without regard to fault and that are statutorily required to be included in a liability policy or equivalent self-insurance program.

"Identification number" or "ID" means the identification number for the insured. This number shall be labeled "ID," except that, in the case of a combined card where the identification number for pharmacy benefits differs from the identification number for other benefits, the number shall be labeled "RxID."

"Insured's name" means the name of the primary insured or, if a separate card is issued for another person included under the primary insured's coverage, the name of the covered person to whom the separate card is issued.

"Issuer name" means the name of the sponsor, carrier, or administrator of the plan (which name may be abbreviated), or the name of a plan of benefits.

"Primary insured" means, in the case of group or individual coverage covering more than one person based on their relationship to an eligible person, such eligible person.

"Processor control number" means the processor control number assigned by the administrator or pharmacy benefits manager. The label for this number is "RxPCN."

11:4–55.2 Requirement to issue cards

(a) Each carrier, multiple employer welfare arrangement, or other provider of a health benefits plan that provides pharmacy benefits shall issue, or cause to be issued, to the primary insured a card satisfying the requirements of N.J.S.A. 17B:30–35 et seq. and this section. At the option of the issuer, additional cards may be issued to other persons included under the primary insured's coverage. Such additional cards shall bear the insured's name. The carrier or other provider may contract with an administrator, agent, contractor or other vendor to issue the cards; however, the carrier or other provider shall remain responsible for the proper issuance of the cards and for their compliance with the law.

(b) A card may be issued for pharmacy benefits only ("stand alone card") or may be issued for pharmacy benefits in combination with other benefits ("combined card").

(c) Until such time as State or Federal regulations are adopted pursuant to the "Health Insurance Portability and Accountability Act of 1996," P.L. 104–191, specifying data elements that may be used in place of the information listed below, the following information must, subject to (e) and (f) below, appear on all pharmacy benefits cards:

1. The issuer name, when required for proper claims adjudication;

2. The ANSI identification number (properly labeled), when required for proper claims adjudication;

3. The processor control number (properly labeled), if required by the party adjudicating claims, directing payment of claims or directing the adjudication of claims;

4. The group number (properly labeled), when required for proper claims adjudication;

5. An identification number (properly labeled);

6. The insured's name;

7. A telephone number for providers to call for pharmacy benefits assistance; and

8. Any other information necessary for proper claims adjudication, except for information provided on the prescription as required by law or regulation.

(d) Where information is required to be "properly labeled," the label (for example, "RxBIN") shall be placed close enough to the information so as to identify that information uniquely.

(e) If a combined card is used, the issuer name for pharmacy benefits shall be:

1. The same as for other benefits; or

2. Clearly distinguishable from the issuer name for other benefits.

(f) The identification number, if a combined card is used, shall be the same for pharmacy benefits and all other benefits, or the ID for pharmacy benefits shall be labeled "RxID" rather than "ID."

11:4–55.3 Time limits

(a) A carrier, multiple employer welfare arrangement, or health benefits provider shall provide each primary insured a new pharmacy identification card within 60 days of a health benefits plan becoming effective.

(b) A card shall be issued to the primary insured within 60 days of the primary insured initially becoming eligible for coverage under an existing health benefits plan (for example, new employee).

(c) A carrier, multiple employer welfare arrangement, or other health benefits provider shall provide each primary insured a new pharmacy identification card within a reasonable time, not to exceed 180 days, after a change in the insured's coverage that changes the information required to be on the card, if the issuance of a new card is required for proper claims adjustment. However, the carrier, multiple employer welfare arrangement, or other health benefits provider shall not be required to issue a new card reflecting changes in information more than once in a calendar year.

11:4–55.4 Access to information

If a card has not been issued, or if the information on a card does not reflect the insured's current coverage, the carrier, multiple employer welfare arrangement or other health benefits provider shall provide the primary insured with a telephone number that can be used to obtain the information that would or should be on the card. This number shall be maintained during normal business hours.

11:4–55.5 Informational filing

(a) Every carrier, multiple employer welfare arrangement or other health benefits provider issuing a card pursuant to this subchapter shall make an informational filing of the form of the card with the Department of Banking and Insurance within 30 days after issuing or causing the card to be issued. The filing shall contain:

1. The form of the card, with all required information specific to the fictitious insured. All variants of the form shall be identified; and

2. An explanation of any variation in information from the information listed in N.J.A.C. 11:4–55.2(c) and this subchapter.

(b) Informational filings shall be sent to the Department at the following address:

New Jersey Department of Banking and Insurance
Attention: Life and Health Division
Pharmacy Benefits Card Filings
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

11:4–55.6 Operative date

This subchapter shall apply to policies or contracts issued and/or renewed after December 15, 2004.

SUBCHAPTER 56. SELF–FUNDED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND INSURED MULTIPLE EMPLOYER ARRANGEMENTS

Authority

N.J.S.A. 17:1–8.1 and 15e; 17B:27C–1 et seq.; and 17B:27A–49.

Source and Effective Date
R.2004 d.212, effective June 7, 2004.
See: 35 N.J.R. 3530(a), 36 N.J.R. 2907(a).

Subchapter Historical Note
Subchapter 56, Self-funded Multiple Employer Welfare Arrangements and Insured Multiple Employer Arrangements, was adopted as R.2004 d.212, effective June 7, 2004. See: Source and Effective Date.

11:4–56.1 Purpose and scope

(a) This subchapter implements N.J.S.A. 17B:27C–1 et seq. by establishing rules for the registration, regulation and reporting of self-funded and partially self-funded multiple employer welfare arrangements (self-funded MEWAs). This subchapter also implements N.J.S.A. 17B:27A–49 by clarifying the requirement that insured multiple employer arrangements (MEAs) notify the Commissioner of certain information on an annual basis.

(b) This subchapter applies to self-funded and partially self-funded multiple employer welfare arrangements as defined in 29 U.S.C. § 1002(40), other than governmental plans as defined in 29 U.S.C. § 1002(32) and church plans as defined in 29 U.S.C. § 1002(33), that provide a health benefit plan or plans which cover the employees of at least one employer that is either domiciled in New Jersey or has its principal headquarters or principal administrative office located in New Jersey. This subchapter also applies to carriers providing health benefits coverage, stop-loss coverage or administrative services to multiple employer arrangements as defined at N.J.S.A. 17B:27A–17.

11:4–56.2 Definitions

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

"Administrator" means a person, partnership, corporation or other legal entity engaged by a self-funded MEWA, as defined in this section, to act as executive director to carry out the policies established by the trustees and to otherwise administer and provide day-to-day management of the health benefit plans.

"Association" means a group of 100 or more persons organized and maintained in good faith for purposes other than that of obtaining insurance, in active existence for more than one year, having a constitution and by-laws that provide that: the association holds regular meetings not less than annually to further the purposes of the members; except for credit unions, the association collects dues or solicits contributions from members; and the members have voting privileges and representation on the governing board and committees.

APPENDIX B

Self-Funded MEWA Loss Ratio Report Form
Small Employer Business
Reporting Year (Year in which this report was prepared) _____
For Preceding Calendar Year Ending December 31, _____

Name of MEWA: _____
Address of MEWA: _____
1. Premiums _____

2. Claims (a. + b.–c. + d.–e.) _____

   a. _____
   b. _____
   c. _____
   d. _____
   e. _____

3. Loss Ratio (2./1.) _____

4. Dividends (.75 x 1.) – 2. _____

Signature of Preparer Date _____ Date _____
Name of Preparer Title _____ Title _____
Address _____
Telephone Number _____

1. Premiums are total earned premiums for small employer business, before any dividends or credits applicable to prior year's Loss Ratio Reports.

2. Claims for small employer business are equal to:

   a. claims paid in the preceding calendar year regardless of year incurred; plus
   b. claims paid from January 1 to June 30 of the reporting year for claims incurred prior to January 1 of the reporting year; less
   c. claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year (as reported in the preceding year's Loss Ratio Report); plus
   d. a residual reserve equal to 3.3 percent of a. + b.–c.; less
   e. a residual reserve (as reported in the preceding year's Loss Ratio Report).

3. Loss Ratio is the quotient, to the nearest.1 percent, of the Claims dividend by the Premiums (2. divided by 1.)

4. Dividends are 0 if the amount on Line 3 is 75.0% or greater. Otherwise, dividends are equal to (75% of Line 1.) minus Line 2.

SUBCHAPTER 57. MANDATED BENEFITS FOR BIOLOGICALLY-BASED MENTAL ILLNESS

Authority

N.J.S.A. 17:1–8.1, 15e and 26:2J–45h; P.L. 1999, c. 106.

Source and Effective Date

R.2005 d.141, effective May 2, 2005.
See: 36 N.J.R. 5080(a), 37 N.J.R. 1523(a).

11:4–57.1 Purpose and scope

(a) The purpose of this subchapter is to implement P.L. 1999, c.106 by specifying that certain exclusions may not be applied to treatment of biologically-based mental illness, and that benefit limits in health insurance policies and health maintenance organization contracts may not be applied to deny medically necessary benefits or services for the treatment of biologically-based mental illness when those benefit limits are not applied in the same manner to treatments for other illnesses.

(b) This subchapter shall apply to all policies and contracts providing hospital or medical services or benefits that are delivered, issued, executed or renewed in this State in the individual, small group and large group markets as follows: all hospital service corporation contracts issued pursuant to N.J.S.A. 17:48–1 et seq.; all medical service corporation contracts issued pursuant to N.J.S.A. 17:48A–1 et seq.; all health service corporation contracts issued pursuant to N.J.S.A. 17:48E–1 et seq.; all health insurance policies issued pursuant to N.J.S.A. 17B:26–1 et seq., 17B:27–26 et seq., 17B:27A–2 et seq. and 17B:27A–17 et seq.; and all health maintenance organization contracts issued pursuant to N.J.S.A. 26:2J–1 et seq.

11:4–57.2 Definitions

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

"Benefit limit" means any restriction, condition, or limitation (including, but not limited to, visit limits, dollar limits and preauthorization requirements) applied to the provision of health care services or benefits in a health insurance policy or health maintenance organization contract.

"Biologically-based mental illness" (BBMI) means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including, but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Carrier" means any insurer authorized to sell health insurance pursuant to Title 17B of the New Jersey Statutes; a health, hospital or medical service corporation; or a health maintenance organization.

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

"Exclusion" means a provision in a policy or contract that limits the scope of coverage by specifying causes and conditions for which benefits are not provided.

"Form" means any individual or group health insurance policy, health maintenance organization contract, any rider or endorsement for use with such policy or contract, certificates and evidence of coverage forms.

"Preauthorization" means a carrier's authorization, using paper or electronic means, for specified services or supplies that is given prior to the date the services or supplies are provided.

11:4–57.3 Exclusions and benefit limits

(a) Notwithstanding the applicability of such exclusions to persons with physical illness, carriers shall not apply any exclusion in a health insurance policy or health maintenance organization contract to deny benefits for services or supplies that are medically necessary for the treatment of covered persons with biologically-based mental illness, so long as such services or supplies are not experimental or investigational. This proscription shall include but not be limited to:

1. Exclusions for the treatment of chronic conditions;

2. Exclusions for physical, speech and occupational therapy that is non-restorative (that is, that does not restore previously possessed function, skill or ability);

3. Exclusions for services rendered after a fixed period of time has elapsed from an injury, procedure or the onset of illness;

4. Exclusions for the treatment of developmental disorders or developmental delay;

5. Exclusions for therapy on a long-term basis;

6. Exclusions for the treatment of behavioral problems; and

7. Exclusions for the treatment of learning disabilities.

(b) Subject to (a) above, carriers may apply benefit limits, including preauthorization requirements, to treatment of biologically-based mental illness only if those benefit limits, including preauthorization requirements, are applicable to treatments of physical illnesses. Visit limits and preauthorization requirements may be applied only to the extent stated in (b)1 and 2 below.

1. Visit limits:

i. Visit limits may be applied to therapy for the treatment of biologically-based mental illness if the same visit limits are applied to therapy for the treatment of physical illness. For example, a limit of 30 speech therapy visits per year is permitted for speech therapy that is required to treat a biologically-based mental illness (such as autism or pervasive developmental disorder), so long as the limit also applies to speech therapy that is required to treat a physical illness (such as stroke).

2. Preauthorization requirements:

i. Preauthorization of all services to treat biologically-based mental illness (that is, blanket preauthorization) is not permitted.

ii. Preauthorization of particular services for the treatment of biologically-based mental illness is permitted only if preauthorization is required for the same or similar services when provided to treat physical illness. For example, a carrier may require preauthorization of partial day hospitalization for the treatment of biologically based mental illness if it also requires preauthorization of intensive outpatient treatments for physical illness such as outpatient surgery, chemotherapy or radiation therapy.

11:4–57.4 Effect on previously filed forms

Forms that have been filed by the Commissioner containing provisions not in compliance with this subchapter shall be deemed withdrawn as of July 1, 2005.